

S. Hrg. 114-427

**TOMAH VAMC: EXAMINING QUALITY,
ACCESS, AND A CULTURE OF OVERRELIANCE
ON HIGH-RISK MEDICATIONS**

JOINT HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

AND THE

COMMITTEE ON
HOMELAND SECURITY AND
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE
ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

MARCH 30, 2015

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Printed for the use of the
Committee on Homeland Security and Governmental Affairs



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TOMAH VAMC: EXAMINING QUALITY, ACCESS, AND A CULTURE OF OVERRELIANCE ON HIGH-RISK MEDICATIONS

MONDAY, MARCH 30, 2015

U.S. SENATE,
COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice at 1 p.m., in Cranberry Country Lodge, 319 Wittig Road, Tomah, Wisconsin, 54660, Hon. Ron Johnson, Chairman of the Committee, presiding.

Present: Senator Johnson, Senator Baldwin, Hon. Jeff Miller, Hon. Ralph Abraham, Hon. Tim Walz, Hon. Ron Kind, Hon. Sean Duffy, and Hon. Mark Pocan.

OPENING STATEMENT OF SENATOR JOHNSON

Chairman JOHNSON. This Joint Field Hearing of the Senate Committee on Homeland Security and Governmental Affairs and the House Committee on Veterans' Affairs is called to order.

Good afternoon. I would like to begin by thanking Chairman Miller of the House Veterans' Affairs Committee for his collaboration and leadership in holding today's hearing. I would also like to thank all of our colleagues for their participation.

Today's hearing has been called to examine the disturbing allegations surrounding the Veterans Affairs Medical Center (VAMC) here in Tomah.

The primary goal of this hearing—and of all of our future actions—is to help prevent tragedies like the ones we will hear about today from happening to other veterans and their families.

I first became aware of the problems at the Tomah Department of Veterans Affairs (VA) following news reports in January of this year. I immediately assigned committee staff to launch an investigation into what had occurred—and was occurring—at Tomah, and the VA's reaction to it. Here is what we have found so far.

In April 2003, Dr. David Houlihan was disciplined by the Iowa Board of Medicine for having an inappropriate relationship with a psychiatric patient. According to the Executive Director of the Board of Medicine, the sanction should have been serious concern for any future employers.

In 2004, Dr. Houlihan was hired as a psychiatrist at the Tomah VA Medical Center.

In August 2005, Dr. Houlihan became Chief of Staff at the Tomah Medical Center.

In November 2007, Kraig Ferrington, a veteran who sought treatment at the Tomah facility for medication management died from a lethal mixture of drugs. Autopsy reports showed Mr. Ferrington had seven drugs in his system.

In April 2009, it was known and documented by employees of the Tomah VA that many of Dr. Houlihan's patients called him "the Candy Man." And they were concerned that veterans were "prescribed large quantities of narcotics." Again, that was April 2009. Almost 6 years ago.

In June 2009, Dr. Noelle Johnson was fired from Tomah for refusing to fill prescriptions that she believed to be unsafe. Dr. Johnson had raised concerns to her superiors and sought guidance from the Iowa Medical Licensing Board and later spoke with the Drug Enforcement Administration (DEA) about Dr. Houlihan.

In July 2009, Dr. Chris Kirkpatrick was fired from Tomah. Dr. Kirkpatrick had raised concerns to his union about over-medication at Tomah. Tragically, later in the day of his termination, Dr. Kirkpatrick committed suicide.

In August 2011, the VA Office of Inspector General (OIG) received an anonymous complaint about overprescription and retaliation by Dr. Houlihan at Tomah.

In March 2012, a second anonymous complaint was filed with the Inspector General (IG) against Dr. Houlihan. The Office of Inspector General examined 32 separate allegations during its 2½ year long inspection.

In March 2014, the Office of Inspector General finished its inspection of Tomah and administratively closed the case without making it public.

On August 30, 2014, Jason Simcakoski died in the Tomah mental health wing as a result of "mixed drug toxicity." Simcakoski was a patient of Dr. Houlihan's. His autopsy revealed he had over a dozen different medications in his system.

In September 2014, Ryan Honl began lodging whistleblower complaints about patient safety and quality of care at Tomah.

On January 8, 2015, this year, the Center for Investigative Reporting published an article detailing over prescription and retaliation at Tomah. The article revealed that veterans and employees referred to the Tomah VA Medical Center as "Candy Land."

On January 12, 2015, Candice Delis brought her father, Thomas Baer, to the Tomah VA Urgent Care Center with stroke-like symptoms. Mr. Baer waited for over 2 hours for attention. That day, the facility's only computerized tomography (CT) scanner was down for routine preventive maintenance. Mr. Baer passed away 2 days later.

On February 6, 2015, the Office of Inspector General finally posted its Tomah health care inspection report on its website.

We continued to gather the facts about what occurred at Tomah. Our investigation is far from over. Revelations of the problems at Tomah have prompted additional whistleblowers to contact our committee with information that indicates systemic problems within the VA health care system.

It is important to acknowledge and thank the members of the media that have uncovered, reported and highlighted the problems

within the VA health care system. Without a free press, few if any of these problems would have ever seen the light of day.

Legislatively, this hearing is just the first step. In order to solve a problem, we must fully understand it and be willing to admit we have one. To that end, today we will hear from surviving family members, former employees, and representatives from the VA and the VA Office of Inspector General.

Tragically, we will hear the stories of two families, the Simcakoski and the Baer families, who lost loved ones during their treatment at the Tomah facility. They have many questions and they have a right to have those questions answered.

I want to convey this Joint Committee's sincere condolences to the family members and friends of Jason Simcakoski, Thomas Baer, Kraig Ferrington, and Dr. Kirkpatrick. We thank them for being here today so that Wisconsin and the American people can hear their stories firsthand.

The lack of public knowledge and scrutiny of the problems—not only at Tomah, but at other VA healthcare facilities—indicates that transparency and accountability both within the VA and the VA Office of Inspector General must be improved.

As the last 2 months have shown, the crucial first step in improving service and the quality of care in the VA health care system is a process for transparent disclosure.

In spite of the revelations regarding the Tomah facility, I still believe that the vast majority of men and women working in Wisconsin's VA facilities are dedicated to providing quality care to the finest among us.

Nevertheless, the VA and the VA Office of Inspector General must take necessary steps to ensure that substandard clinical practices and the retaliatory tactics used at Tomah never occur or go unreported again.

We owe our veterans the best possible treatment and care. Hopefully, with proper oversight, increased transparency and swift accountability within the VA, that goal will be achieved. Chairman Miller.

OPENING STATEMENT OF CONGRESSMAN MILLER

Chairman MILLER. Thank you very much, Mr. Chairman. I am Jeff Miller, Chairman of the House Committee on Veterans' Affairs. I am from the First District of Florida.

And, while I am here under circumstances that are disturbing, to say the least, I am grateful to be in Tomah with each and every one of you this afternoon.

Ladies and gentlemen, those of us up here on the dais right now are from different political parties, different houses of Congress, different parts of this State and different parts of the country. But let me say this, we are all united here in Tomah today, because partisanship, stovepipes, and gridlock have no place where our Nation's veterans are concerned.

Let me begin my statement by expressing my condolences to the Simcakoski family and the Baer family and to all of you here today who have lost loved ones or have been left to carry the scars of poor treatment by the Tomah Department of Veterans Medical Center.

However, let me assure you that your pain serves a purpose and your calls for help and change have been heard.

Concerned employees and worried veterans have tried to blow the whistle here for years, only to be met with seemingly silence by the Inspector General and the Department of Veterans Affairs.

When the problems finally got the attention that they deserved, the IG and the VA learned what so many here had known and been saying for a long time. Some providers were recklessly providing opioids and other high-risk medications that, in some cases, were actually harming veteran patients and that facility and the Veterans Integrated Service Network (VISN) leaders allowed a culture of fear, reprisal and retribution to fester until it infected staff morale and impacted patient care.

Unfortunately, many of the issues surrounding medication management and a lack of accountability that we are going to discuss today are not outliers, but they are symptoms of system-wide issues that our veterans and their families face in communities like this one every single day.

I recognize that pain—particularly the chronic pain and accompanying comorbid conditions that many of our veterans experience—is complex and difficult to treat.

I also recognize that VA is joined by the medical community at large in grappling with how best to treat chronic pain and ensure safe, effective use of opioids and other high-risk medications.

However, I have heard VA officials use these two facts as de facto excuses for irresponsible medication management practices and systemic lack of accountability for far too long, while our veterans and their families continue to suffer the devastating consequences of VA's inaction.

It is time for a new message.

We cannot rewind the clock and bring to light before yet another year of inaction passed—the results of the IG's initial 3-year investigation that found serious concerns.

We can never bring back Jason Simcakoski or Thomas Baer.

But we can use the lessons we learned here in Tomah to improve the care our veterans receive and ensure that no other veterans, their families or VA employees suffer like some have here.

I appreciate each and every one of you being here today. I look forward to your testimony.

And I yield back to the Chairman.

Chairman JOHNSON. Thank you, Chairman Miller. Before I turn it over to Senator Baldwin, I do ask unanimous consent to enter all of our opening statements into the record¹ and our ranking member, Senator Tom Carper, has also offered an opening statement that I also ask be entered in the record.²

Without objection, so ordered.

Chairman JOHNSON. Senator Baldwin.

¹The prepared statement of Senator Johnson appears in the Appendix on page 63.

²The prepared statement of Senator Carper appears in the Appendix on page 66.

OPENING STATEMENT OF SENATOR BALDWIN

Senator BALDWIN. Thank you, Chairman Johnson, Chairman Miller, for holding this hearing here today. And to my Congressional colleagues in the Wisconsin delegation, thank you for joining us. And a special welcome to Congressman Walz and Congressman Abraham for visiting Wisconsin today.

I want to echo the opening statement of Chairman Miller, by noting that, the fact that there are members here from both parties—from both the Senate and the House sends an important message to this community that we share a bipartisan commitment to get to the bottom of the problems at the Tomah VA, and to work together across party lines to make sure that they never happen again.

I hope and I trust that I speak for all of us when I say there is no reason for, and no room for politics when it comes to ensuring that our Nation's veterans receive the timely, safe, and highest-quality care that they have earned.

I would also like to take an opportunity to say thank you to our panelists for joining us here today. In particular, I have tremendous respect for the courage of Candace, Heather, Marv, Ryan and Noelle.

Stories that you are going to share today are extremely powerful. They are stories of a sacred trust that we must have with our veterans and their families and stories of how that trust has been broken. Tragic stories of loss.

Today we are here to fix what has been broken. And to work together to restore that trust. And I want you to know that the stories you give voice to today will help us do that for our veterans.

The problems at the Tomah VA are both sobering and have had tragic consequences. Going back to 2006, veterans who were patients at the Tomah VA have tragically lost their lives.

Veterans who served our country, Angela Colby, Michael Bobak, Jacob Ward, Derik McGovern, Kraig Ferrington, and Jason Simcakoski, were all under the care of the former Tomah Chief of Staff and treated with prescription drugs and all of them subsequently died of a drug overdose.

In fact, according to his sister Kari, who is with us here today, Mr. Ferrington, an Army veteran from De Pere, Wisconsin, died from a lethal mixture of prescription drugs in 2007, while under the care of the former Chief of Staff. The same cause of death that would tragically take the life of Jason Simcakoski some 7 years later.

These are six examples of a larger problem that is in desperate need of solutions today. As we all know, after two decade-long wars, a large number of our service members are coming home with the damage of combat.

Our veterans and their families are facing the difficult challenge of facing physical injuries and post traumatic stress disorder (PTSD) and other mental illnesses. We must confront these problems more aggressively and more effectively and help them meet that challenge.

I believe the VA's overreliance on opioids has resulted in getting our veterans hooked instead of getting them help.

Over prescription of opioids at the VA is clearly a root problem, but we must not lose sight of the fact that it is growing into a weed. A weed of addiction whose impact is being felt beyond the VA walls. The devastation of addiction on families and our communities that is being grown at the VA is stunning.

Reports indicate that 6 years ago, a Marine Corps veteran was stoned on painkillers and tranquilizers from the Tomah VA while driving and killed a 6-week-old child, Ada Mae Miller.

As the Center for Investigative Reporting wrote about the Tomah VA Medical Center, Ada Mae's death is one of dozens of tragedies that begin to hint at how the flood of narcotics from the VA scarred this region.

The fact is, the problem of overprescribing at the VA and the collateral damage of addiction is not unique to Wisconsin. We are not alone.

The ripples are indeed being felt across America in communities we work for every day in Washington D.C.

The families we have a responsibility to represent are struggling with the loss of a husband or wife, son or daughter, father or mother, sister or brother, to addiction whose root is planted within the VA system. It is our job to make sure that they do not feel alone and I believe we have a shared responsibility to do everything we can to pull this root out.

I thank you for providing me with the opportunity to join you today. And I look forward to continuing my work with this community and my colleagues in Congress to address these problems and put the solutions in place to prevent these problems and tragedies from ever happening again.

Chairman JOHNSON. Thanks, Senator Baldwin. Congressman Walz.

OPENING STATEMENT OF CONGRESSMAN WALZ

Mr. WALZ. Thank you, Chairman Johnson and Senator Baldwin, to my colleagues and a special thank you. It has been an honor of mine to serve with Chairman Miller for the past 8 years on the Veterans' Affairs Committee, and I can tell you no one brings more passion and integrity to the issues to care for our warriors than the Chairman does.

I am Tim Walz. I am a 24-year veteran in the military and I serve in the First Congressional District of Minnesota, and my District goes up to the Mississippi and many of my veterans in southeast Minnesota use the Tomah Facility.

This hearing, and for our witnesses who are here, fulfills our Constitutional responsibility to provide oversight, and to provide oversight of the VA, and very few committees have the immense responsibility of that oversight, means the care of those who are willing to put their lives on the line and their families to serve this Nation, so getting it right, as I mentioned to some before this hearing, this is a zero-sum proposition. We understand many get quality care. We understand many are getting what they need. But if one family does not receive it, then we have failed. And that is an understanding that, that, amongst this family, runs deep.

I know each of you, if there was anything we could do, and I say this to you as a father, a husband, a son and a veteran, if we can

turn back and make this right, everyone here would, would wish that more than anything.

But what we can do is—two things. We can make sure accountability and justice is provided to you, and we can make sure that no other family goes through this, so I echo what my colleagues said to each of you.

I cannot even imagine your pain and I will not give you lip service. I spoke with one of Mr. Baer's family members, who is a 23 year E8. She is pretty much not interested in lip service and she's pretty much not interested in a show. She's pretty much interested in results. And I think everyone up here clearly understands that.

And so today, the purpose of it is to start to provide you justice, to try to understand exactly what happened, and then to start coming up with solutions.

And, the issue here runs deep and it is something, it is not new. It's not confined to the VA. It is in the private sector also—pain management with injuries, especially injuries associated with catastrophic war injuries or service-related injuries. And this is something we've tried to do, we've put in place, reaching back decades.

And I have worked with Chairman Miller on things we put in to try and address this issue. In 2008 we had a bill dealing with chronic pain management and overreliance on opioids. It has been there, but for each of your families, what's it is telling me, it is not working.

My colleague, Mr. Kind, and our colleague from up north, Mr. Ribble, introduced recently a piece of legislation to build on that, to make it even stronger. And so what needs to come out of this today, and what I thank each of you is, we need to understand what happened. We need to understand what went wrong. We need to make sure that there is accountability, and if it includes punishment to those and justice for you, that needs to happen, and then we need to find those solutions. We need to implement things that are working and I hope to hear from the VA today the things they've initiated. And there are bright spots of things that are happening. And that is going to be amongst you, frustrating at times to hear, but please understand, for us, what you are going to tell us and help us understand is going to ensure that not another family sits there.

And I would close with our two folks here sitting at the end, along with the media—as Senator Johnson pointed out—for bringing this to the attention. It is a pretty high calling and a pretty difficult thing to do to stand up in the face of retribution to bring things to light that are harming our veterans, and I think, and I have witnessed it in the House Veterans' Affairs Committee that tolerance for retribution on whistleblowers is less than zero, because it is a cancer that prevents us from providing the care that our veterans need if anyone in that organization is stymied from being able to speak about what is right and what is wrong.

And so our commitment to you, as it has always been, is to make sure that justice is served to you, those who were bringing it up. You were not doing it for yourself. You were doing it for their loved ones, and, perhaps, had we listened earlier, they would not be sitting at the table, because I know they would rather be somewhere else.

So I want to thank you for that.

I hope we find answers here today. Our Republic requires us to have these difficult conversations. Our warriors and their families are absolutely counting on us. And what we cannot do is undermine the faith of the care we are going to give our warriors amongst those who are serving, so I want to thank everyone for being here and thank the Chairmans for initiating this hearing.

I yield back.

Chairman JOHNSON. Thank you, Congressman Walz.

Like you as someone who has served your country in the military, we have a lot of vets and their families here, so I think I speak for everybody here on this Joint Committee when we thank you sincerely for your service as a Nation.

It is the tradition of our Senate Committee to swear in all the witnesses, so if all witnesses, would you please stand and raise your right hand?

Do you swear the testimony you will give before this Committee is the truth, the whole truth and nothing but the truth, so help you, God?

Ms. DELIS. I do.

Ms. SIMCAKOSKI. I do.

Mr. SIMCAKOSKI. I do.

Mr. HONL. I do.

Ms. JOHNSON. I do.

Chairman JOHNSON. Thank you. Please be seated.

Our first witness is Ms. Noelle Johnson. I believe it is Dr. Johnson, is it not?

Dr. JOHNSON. Yes.

Chairman JOHNSON. I will say Dr. Johnson, is a former pharmacist at the Tomah VA Medical Center from 2008 to 2009. She is currently an employee of the VA facility in Iowa.

Dr. Johnson, go ahead.

**TESTIMONY OF NOELLE JOHNSON,¹ PHARM.D., BCACP, CGP,
URBANDALE, IOWA**

Dr. JOHNSON. I would like to take the opportunity to thank the Committee for having this hearing today and allowing me to have a voice and speak out for our veterans.

I worked at the Tomah VA as a Clinical Pharmacy Specialist from July of 2008 to June 2009. I was fired after refusing to fill several narcotic prescriptions prescribed by Dr. Houlihan that I believed to be unsafe. I filed a whistleblower complaint with the Office of Special Counsel (OSC), which was denied, and later the Merit System Protection Board (MSPB). The VA requested Federal mediation. And I settled out of court in 2010. I was then fully reinstated.

I do believe that I was terminated for blowing the whistle and I was contacted by the DEA and agreed to interview with them. I met with the DEA in June 2009. And I was fired a few weeks later. In my Office of Special Counsel complaint, Dr. Houlihan and several others referenced that I had turned him in to the Inspector General. I believe this played into my termination. I truly believe

¹The prepared statement of Dr. Johnson appears in the Appendix on page 73.

that Dr. Houlihan is a dangerous man and what makes him so dangerous is a lack of respect for the medication in which he prescribes. Whatever his motives for prescribing the current doses of the medication is almost irrelevant. To this day I still question his motives, whether it be power, monetary gain, negligence, or ignorance. Maybe all of the above. The truth of the matter, the quantities of narcotic medications coming out of the Tomah VA facility is irrefutably unsafe. This has been demonstrated by several cases of overdose and death. Over 2,000 911 calls were made from the Tomah VA Medical Center with 24 unexpected deaths over 5 years. This is unacceptable. Three of those deaths occurred in a 4-month span timeframe in the year that I worked at the Tomah VA.

The three questions that need to be asked are simple. First, what makes the Tomah VA patient population so complex, as the Tomah Director put it in his television debut, that they require the number of narcotics that are being dispensed? I am currently working as a double board certified Clinical Pharmacy Specialist in a pain management clinic at the Des Moines VA. I am currently the facility lead for the National Opioid Safety Initiative. And I can assure you the patients at the Tomah VA are no more complex than any other patient that I see on a daily basis. At that point we are not even prescribing one fourth of the current narcotic medications that the Tomah VA is. Specifically as the Veterans Health Administration (VHA) Directive is to limit the morphine equivalents to less than 200 milligrams per day and limit the combination of opioids and benzodiazepines due to the increased risk of mortality. I do not believe that Tomah would be in compliance with this National Directive. The thing I am struggling most with is to understand the variance between what the Undersecretary's team found and the report that was administratively closed by the Inspector General. Unfortunately, for all the veterans receiving care at the Tomah VA, the considerable variance that was not enough to warrant a serious consideration by the Inspector General, as the investigation was administratively closed, led to continued harm of our Nation's veterans.

The second thing. What exact type of pain is the Tomah VA trying to treat that they are prescribing the dangerous quantity and dosages of this medication? Studies show that no proven long-term benefit of opioid medications, let alone the significant doses that were being prescribed. As a pain specialist, I can assure you that if someone was actually taking those medications in the amounts that were prescribed, they would have serious side effects or consequences, which leads me to believe, in part, that the veterans are not taking all of the prescribed medications and are at high risk for diversion. This was a substantiated finding by the Inspector General. They substantiated the allegation that negative urine drug screens (UDS) were not acted on and that controlled substances were prescribed in the face of a negative urine drug screen.

The third issue is why is a psychiatrist prescribing opioid pain medications at the Tomah VA facility, period? This is beyond their scope of practice.

I am tremendously disappointed in our Federal system and our current authoritative figures that are to be governing our agencies set in place to protect our veterans and employees. I have inter-

viewed with the DEA three times and had a thorough interview with the IG. Of the 32 allegations that were investigated, many were unsubstantiated. What the disturbing thing is, is that I lived the torture and saw the unsafe practice daily. I can attest to several of those 32 allegations and believe the majority should have been substantiated. The Inspector General's investigation did substantiate several allegations. However, they still did not find any conclusive evidence affirming criminal activity, gross clinical incompetence or negligence, or administrative practices that were illegal or violated personnel policies. This is unfathomable for the following reasons.

I advise that I alerted Dr. Houlihan on a few different narcotic medications and scripts. All were very concerning for safety reasons. However, the one that stands out the most to me is an OxyContin prescription that a local medical doctor was prescribing. He was also tapering this medication because the patient tested inappropriately positive for methadone, a drug that neither provider was prescribing. At that point in time the patient was double-dipping. He was getting OxyContin from the VA and from a local medical doctor with refill dates only a week or two apart.

In addition to the inappropriate urine drug screen, which the VA did not obtain, the abuse of opioids, the patient left his cell phone in the pharmacy. The person on the other end was trying to buy medication from this veteran. All of this was documented and Dr. Houlihan rewrote the prescription for OxyContin three times a day. This was an increase in the frequency prescribed. This supports the substantiated findings that Dr. Clancy's team expressed. As expressed above, the veterans were still prescribed narcotics in the face of aberrant drug-related behavior. From a clinical standpoint, I am unclear why Dr. Houlihan prescribes these medications in the manner in which he does. What matters is the standard of care. There is a standard of care that is set in place for providing safe and effective care to our veterans. For example, there was 1,080 immediate release morphine tablets that were dispensed. When I confronted Dr. Houlihan, he refused to change the patient to a long-acting medication, which would have been the standard of care or adding a nonnarcotic medication to treat his neuropathic pain. He continued to prescribe 36 tablets a day to known substance abuser who was overusing his morphine while in the hospital.

Another example is a prescription of 1,447 milligrams of morphine equivalent per day. Dr. Houlihan and Dr. Hyde worked on this prescription together. The patient had dangerously increased his own medication and they gave the patient a 30-day supply when he was supposed to be admitted for inpatient facility monitoring for pain management. He was not admitted. That is how you have accidental or nonaccidental overdoses in your parking lot. I retrospectively reviewed the patient's profile the following week. And, as I said, he was not admitted according to the plan of care. I was later kicked off the new pain committee and opioid work group that I had been assigned to or appointed by the Quality and Safety Director by Dr. Houlihan, who promptly replaced me with Dr. Hyde, which I do not believe to be a coincidence. Dr. Hyde is now being investigated by the Wisconsin Department of Profes-

sional Services. I had very little interaction with Deb Frasher. The only thing I can say is that I heard her say that everyone needed a cocktail, which consisted of an opioid, a benzo, a stimulant, and a sleeping medication.

My question about her is, again, if she's treating mental health, then why is she prescribing 5.3 million milligrams of morphine equivalent in one year's timeframe? What is she treating? When it did become acceptable or the standard of care to treat psychological pain with opioids? This finding was unsubstantiated by the Inspector General. However, I can tell you that I saw this indication for opioids in the chart several times.

The veterans in the Tomah VA appeared extremely overmedicated. Several veterans appeared to be suffering with extrapyramidal side effects due to the unsafe combination of medications being prescribed. The list of medications the Tomah VA prescribed Jason Simcakoski did not follow evidence-based guidelines or the standard of care. For example, he was prescribed a weak opioid that was prescribed with Suboxone which should never be done. Diazepam was prescribed at above the maximum recommended dosage. He was also being prescribed duplicate benzodiazepine therapy with diazepam and temazepam, it was dangerous and not the standard of care. He was also on several other interacting medications that effect serotonin which put him at high risk for serotonin syndrome, which can be lethal, and, unfortunately, it was. One of my main concerns about the care provided at the Tomah VA to Jason was that Jason's care and the mixed drug toxicology that eventually led to his death did not likely occur overnight. I would have suspected that the veteran would have displayed signs and symptoms of the central nervous system (CNS) depression, and he likely did. If that was the case, was there evidence of gross clinical incompetence and negligence? That veteran's death was a preventable tragedy. Had the Inspector General done their due diligence and reported their findings, despite the administrative closing of the investigation, the outcome for Jason could have been a very different one.

The majority of my colleagues, with the exception of Dr. Hyde, had agreed with my clinical concerns. I alerted my Chief of Pharmacy, Dr. Erin Narus, who ordered me to illegally partial a methylphenidate script prescribed by Dr. Houlihan because neither of us concurred with the current dosing regimen and it was prescribed above the maximum recommended dosage. I told my Service Line Chief, Jeff Evanson, and his response to me being asked to do something illegal was, why are you trying to cause trouble? Why are you trying to throw Erin under the bus? If Houlihan wants you to fill that prescription, you have no right to say no. I reported my concerns to the President of the Union, the VISN pharmacy leaders, the DEA, and later the Inspector General, as well as the Wisconsin Board of Pharmacy. I alerted my licensing agency, the Iowa Board of Pharmacy, who advised me not to fill the prescriptions and bring the matter to local authorities. The unfortunate part of all of this is that despite all who knew, nothing has been done. The true tragedy is that more veterans had to die because the Office of Special Counsel determined that my clinical opinion was different than Dr. Houlihan's.

The depth of this tragedy is far reaching. I recently received a pain management consult at the VA in Des Moines for a veteran that was treated by Dr. Houlihan and Deb Frasher. He had a long-standing history of substance abuse. He was previously taken off opioids for a previous overdose. He was later put back on large doses of benzodiazepines and opioids by Dr. Houlihan and he has subsequently overdosed two times in the last 2 months. He is now an inpatient in our facility being taken off all of his medications. I am unclear how the Inspector General could not substantiate the findings that no conclusive evidence of gross clinical incompetent or negligence was found. Veterans lost their lives because of this prime example of gross clinical incompetence and negligence.

I have personally dealt with the repercussions of the administrative practices that were illegal and violated all sorts of personnel policies. I was asked to do something illegal. I refused. I blew the whistle and was fired for standing up for doing what was safe and right for the veterans. The Inspector General did find that pharmacy staff uniformly indicated that they were reluctant to question any prescription ordered by Dr. Houlihan or the aberrant behavior by his patients because they feared reprisal. If all of these findings were unsubstantiated, why have so many clinicians left the Tomah VA? The one pharmacist who was brave enough to stand up and question those prescriptions was fired. The precedence of what not to do if you value your job was set.

My second Chief of Pharmacy, Tom Jaeger, reported that he was actually coerced into writing his personal statement that helped lead to my termination. He agreed to take it back and he resigned 2 days after my termination. My clinical colleagues, Heather Asthmust and Rebecca Bell, were pulled into Houlihan's office where he essentially told them, if they valued their job, they would not question him like I did. A former provider resigned in lieu of termination after refusing to write for an opioid that a veteran did not test positive for in his urine drug scene. I was told in the pain committee meeting that we were not to be drug testing our patients, as when they did not test positive for the substance prescribed, and we continued to prescribe the medication, then we were liable. I do believe that is the point of the urine drug screen is to substantiate use and misuse of high-risk medications for the safety of our veterans and the public. Dr. Houlihan proceeded to tell the Union Steward that there would never be a pain clinic at the VA and if pharmacy took over management, pain management, the patients would start dying, after which they would bring their guns to pharmacy and start shooting.

I continue to have grave concerns about the clinical abilities of several other providers at the Tomah VA, including concerns that were ignored or unsubstantiated by the Inspector General. What will it take for those in a position of authority to do some significant actions? How many veterans' lives need to be lost? We are supposed to be taking care of these veterans returning from war, not creating a war that they will not survive. It is all of our responsibility to stand up for these veterans' safety and not contribute to the tragedy that has cost so many lives. The leadership at all levels—Tomah, VISN, the Veterans Affairs Central Office (VACO), and the Inspector General need to be held accountable or true

change will never prosper and veterans will continue to suffer the ultimate sacrifice.

Chairman JOHNSON. Thank you, Dr. Johnson. We will, by the way, enter full written statements into the record, if we could just ask the witnesses to keep pretty close to the 5 minutes so we can keep the hearing moving.

Our next witness is Ryan Honl. He's a former employee of the Tomah VA Medical Center, who worked as a secretary in the Hospital's Mental Health Clinic. Mr. Honl.

TESTIMONY OF RYAN HONL,¹ FORMER EMPLOYEE OF TOMAH VA MEDICAL CENTER, TOMAH, WISCONSIN

Mr. HONL. Chairman Johnson, Chairman Miller and distinguished Members of the committee, as well as the press.

I am the one who blew the whistle on the alarming irregularities concerning unethical practices at the Tomah Veterans Affairs Medical Center. I am also a disabled combat veteran and received care at the VA for 15 years, up until last year. I enlisted as a combat engineer after high school, served in Desert Storm, earned an appointment to West Point, and then became a commissioned infantry officer before being medically discharged with, among other things, PTSD. It is important to note that I was only the spark to set off years of employees raising concerns about the dangerous prescription and distribution of narcotics, as well as the resulting retaliation. The results were to the detriment of the health of veterans, and, in some cases, the deaths of veterans. The system was slow to respond, but quick to silence those who raised concerns. I just wish the whistle I blew would resurrect those who have died due to mistreatment.

Initially my complaints to the VA Office of Inspector General mainly centered on a hostile work environment that tolerated fraud and abuse. I only briefly mention that, although I was not a witness, since I was a secretary, to the overprescription of narcotics, there was a widespread concern among my coworkers. I simply stated in my complaint that it should be looked into. There is a culture in the VA where cronyism runs rampant leaving incompetence in charge at all levels that tolerates unethical practices. Once I came out publicly blowing the whistle, I had current and former employees contact me with information about other unethical activities up to and including patient harm and patient death.

There is a lack of accountability in VA leadership. There were years of complaints concerning a retaliatory environment and patient harm, yet both VA leadership and the VA Office of Inspector General ignored or handed off complaints back to the Tomah facility so it could investigate itself. There is a culture in the VA of admitting no wrongdoing. Pain management and wait times are simply a symptom of a far larger lack of accountability. Tomah is not an island onto itself. Dr. Houlahan should have been held to account years ago, by not just Facility Directors, but those outside of the Tomah Facility and VISN 12 leadership. Yet the system protected him and not our Nation's veterans.

¹The prepared statement of Mr. Honl appears in the Appendix on page 147.

The VA Inspector General's office is broken. If it were not for a Freedom on Information Act (FOIA) request done by Senator Baldwin's office last summer, no one would have known about the issues in Tomah. It took an investigative journalist, Aaron Glantz, at the Nonprofit Center For Investigative Reporting to do the job that the VA Inspector General was incompetent to do. The report verified everything people had been talking to me about since I blew the whistle—excessive prescribing of narcotics, drug diversion, patients not using their narcotics. A physician in 2009, Dr. Chris Kirkpatrick who raised concerns about Dr. Houlihan's prescribing practices, was terminated and went home and committed suicide.

Tomah municipal police reports of veterans selling their medication. Retaliation against those who spoke up concerned about their licenses, such as the five pharmacists who spoke with investigators about the dangerous levels and early filling of narcotics and resigned or were terminated.

Most incredible to me was a statement about the perception of retaliation, implying that it did not really exist. Yet numerous people in the report had been forced out of the facility for simply raising concerns on behalf of veterans.

Inspector General Richard Griffin said that he would not have done anything different and no one else would have either. Ms. Gromek stated that the report could not be released because of personally identifiable information (PII). The report received through the FOIA request was already redacted.

I will give you two personal examples of retaliation, even after resigning from the VA. After requesting a patient access report of my electronic medical records, I discovered that a half dozen Tomah employees had accessed my electronic medical records after I left the facility over a supposed mix-up in Secretary Robert McDonald's office, according to Mario DeSanctis, concerning a complaint about my prescriptions. Although I had never received care or received prescriptions from the Tomah VA, there were a half dozen Tomah nonpharmacy employees over a pharmacy complaint in my records. I had originally informed my supervisor, Lisa Noe, that I had a PTSD diagnosis since I was in vocational rehabilitation with the VA, and my counselor in Indiana needed to know information about my employment at the VA. I asked that this remain in confidence. However, as soon as I blew the whistle, I started hearing from coworkers about my instability. Ultimately, the most troubling occurred since everything came out in the media. Dr. Houlihan's attorney sent a letter to me threatening a lawsuit, a man that I reported. In an interview with the Milwaukee Journal Sentinel, his attorney, Frank Doherty, alluded to my mental health status, which had nothing to do with my credibility. And it just so happens that Frank Doherty's wife, Lisa Doherty, who is a narcotics compliance officer, reported directly into Dr. Houlihan.

While investigators were in the Tomah VA, Police Chief Huffman directed that a police report be done on me by my former supervisor, Lisa Noe, and two coworkers, Leesha Dukes and Rachel Fleming, 4 months after I resigned over a supposed threatening incident that took place while I was an employee before I resigned.

You can see the police report that someone leaked to me in my submitted documents. Among the terms used in that report was I

was threatening. I was red in the face. I was unstable. And then the word that was the most damaging for mental health professionals in Tomah—that I was crazy. It is in the police report—that word. As long as you speak out, raising concerns, whether an employee or a former employee, the VA will do everything in its power to discredit you, and the OIG will just call it a perception.

In conclusion, the greatest problem requiring immediate change is for President Obama to nominate a permanent Inspector General and for the Senate to confirm without bipartisan horse trading. The VA Office of Inspector General has the blood of veterans on its hands. Senator Baldwin and Senator Johnson have each asked the White House to nominate a new Inspector General. Elected officials need to make sure that when they hear of serious problems in a VA Facility, they direct those concerns far higher than the Facility level. When, as in Tomah, unethical practices go all the way up to the Facility Director, sending those concerns back to that Facility Director only leaves the fox to guard the hen house. As Congressman Kind stated, when he came to the Tomah facility last summer, there was not a peep from Mario DeSanctis that there were any problems. Certainly no narcotics problems. Nothing. The VA Inspector General should, at minimum, provide a summary of problems in a Facility.

In the case of Tomah, when someone from Congress comes calling, they should already have a top line of any concerning investigations. This Inspector General's office did not even keep senior VA leadership informed. Again, the main problem underlying scandal after scandal is a culture that lacks accountability. Rogue doctors and those who supervise them will never care what the rules are, or they will never follow a pain management system, if they are not held accountable as has been the case in Tomah. There is a cancer within VA leadership that requires excision, not promotions, not transfers and not bonuses.

Thank you.

Chairman JOHNSON. Thank you, Mr. Honl.

Our next witness is Mr. Marvin Simcakoski. Marv is the father of Jason Simcakoski, a 35-year-old marine who passed away from a reported drug overdose at the Tomah VA Medical Center. Mr. Simcakoski.

TESTIMONY OF MARVIN SIMCAKOSKI,¹ FATHER OF JASON SIMCAKOSKI, STEVENS POINT, WISCONSIN

Mr. SIMCAKOSKI. Thank you for having me here today.

My name is Marv Simcakoski. I am Jason Simcakoski's dad. I want to start off by saying that August 30, 2014, was the hardest and most painful day of my life. There is not a day that goes by when I do not relive that morning. I regret leaving my son in his room alone that morning, only to get a call hours later that he stopped breathing. I cannot get that thought out of my head. I wish I would have been there for him. I loved Jason and still do with all my heart and miss him every day. Jason was proud to be a marine and to serve his country. He loved his fellow Marines.

¹The prepared statement of Mr. Simcakoski appears in the Appendix on page 249.

This is a summary of some of the important issues to the committee as I understand them. I really got to know and understand how Jason struggled with his addiction problem, only to have it overfueled time and time again by the Tomah VA doctors. I have argued with Jason's doctors for the last 4 years about them over medicating him. I was always told that I was not their patient, even thought I was his dad who truly cared about him.

What I would like to know is, if Jason was their son, would they have had him on all these medications? When Jason came home from one of his inpatient stays, the doctor had him on so many meds, Jason and I were confused by all the different medications he had to take. His doctor sent him a 3-month supply of lorazepam and he took them all in 4 days and almost died. I was mad and confused. Why would a doctor that works with patients with addiction problems send a patient 3 months worth of benzodiazepines?

After his doctor stopped the benzodiazepines and eliminated some of the other meds, Jason started doing a lot better and I started giving him his meds daily, 7 days a week.

Then one day about a year ago, Jason's dog, which he loved, was run over by a car in front of him. Jason started to unravel. I took him back to the Tomah VA and he was assigned to a new inpatient doctor, Dr. Davis. My wife, Jason, and I met with her and discussed his treatment plan. This new doctor told us that Jason did not need all these meds and she was going to take him off most of them. My son stayed at the Tomah VA for 3 months.

Toward the end of his 3-month stay in 2014, he was doing real well until his doctor put him on a new drug, Geodon. Then everything started to spiral downhill. Jason's anxiety level went way up. He could not sleep. He started having bad thoughts.

He told his doctor about all of these issues and that he did not want to take the medicine any more. She told him, if you do not take it, you will be discharged the next morning. Jason kept taking it until he could not stand it any more. He pulled the fire alarms and went crazy. His doctor was going to put him in lockdown for 2 months because of it.

My son made a good point to me. He said, why am I getting punished for something she made me take? Dr. Davis then gave Jason the option of going to the Madison Facility or into the lockdown at the Tomah VA. He did not want to go into the lockdown, so he transferred to the Madison VA the same day. He was told there that he was overmedicated on Valium and Geodon and that the Geodon can make people crazy. They released him the next day. He was sent home to try to wean himself off these medications, which I know was next to impossible.

After being home for about 2 weeks. Jason still could not do much more than get out of bed and eat, so I took him back to the Tomah VA the day after my father's funeral. Jason was not able to attend his grandfather's funeral because of the effects of withdrawal.

Jason told me on the way down to Tomah that if he could be like anybody, he would be like his brother Chad, because Chad was normal, and he did not have all these daily struggles. The last 2 weeks that Jason was in Tomah he was doing OK until his doctor put him back on Geodon. He sent me a text 4 days before he died and told

me he could not take it any more. He was going crazy and he reached out to me to help him. I made various calls to various offices above his doctor's head. Jason called me within 2 hours. He said somebody was helping him. I met with his doctor the next day, Thursday, with my son and a Patient Advocate.

When we sat down in the room, his doctor turned and pointed at me and she said that I caused her a lot of trouble. She said she spent 2½ hours at meetings because I went over her head and she could have been taking care of my son. She also said I may know how to build houses and pound nails, but I do not know anything about taking care of my son.

This really hit me hard. To have Jason's doctor tell me I do not know about my son and that I caused her a lot of trouble for trying to help him was difficult to hear. Jason called me that night before he died and wanted me to bring his truck the next morning. He was all excited about coming home that following Monday for his daughter's birthday that week. His wife, his daughter and I arrived as promised.

Usually when we would come to see him he is waiting. This time there was no Jason. I went to the nurses' station and asked where he was. And they said he was in his room with a migraine, which was strange, because he never had a migraine before.

I went into his room and he was lying on his side with his hand on his head. I asked him what was the matter and he started to talk, but I could not understand him, because he was on so much medication. I went to the nurse's station and asked them what was wrong with Jason and the nurse told me that he would be fine in a couple hours. They had given him another med for a migraine. This medication did not show up on the autopsy report. It was Fioricet. I went back to his room and we stayed a little longer. He waved us off to go and he went back to sleep. We left not knowing that we would never see him alive again.

About 5 hours later we get a call from the Tomah VA stating that Jason had stopped breathing. They were working on him, trying to resuscitate him, but it was too late. He never got to drive his truck or come home for his daughter's birthday.

I then find out he was still on all the medication, when the doctor told us she was going to take him off most of them. I think that was insane. Later I find out they also had Jason on pain meds, Tramadol, and sent him a bottle of 56 to his house. Why do you put someone with an addiction to pain meds on pain meds? I cannot begin to tell you how angry that makes me. I would like one of these doctors to tell me how mixing all of these drugs they had Jason on, was taking, was going to do him any good.

Why does not the Director of the VA Facility take blame for all of this? Is not he in charge? I am an independent contractor in the Stevens Point area, and when anybody that works under me on a job site does something wrong, I am responsible because I am in charge.

If this Facility will not take responsibility for its wrongdoing, then I think the system is totally screwed up. I think all who had part in my son's death should be held accountable. If they are not, then what kind of message are we sending? Is it not OK to have

a patient die in the mental health ward because of overmedicated by the doctors and no one is a fault?

If after today's hearing nothing major gets changed, then I think people will lose faith in our government. Let's make some historic changes that we can all be proud to be part of. Give these veteran men and women a fighting chance for a bright future instead of a cloudy one from being overmedicated so they know what it feels like to be normal. I think this is going to be a great chance to have all government parties work together to show veterans you really do care. After all, these people should be the most important priority to all of us because they are our real life heroes of this country.

I am proud my son was a veteran and he will always be my hero.
[Applause.]

Chairman JOHNSON. Thank you, Marv, for that powerful testimony.

Our next witness is Heather Simcakoski, the widow of Jason. Heather.

**TESTIMONY OF HEATHER SIMCAKOSKI,¹ WIFE OF JASON
SIMCAKOSKI, STEVENS POINT, WISCONSIN**

Ms. SIMCAKOSKI. Thank you for having me here today.

My name is Heather Simcakoski. I am the wife of Jason Simcakoski and mother of our 12-year-old daughter.

Jason and I met 13 years ago while both serving in the Marine Corps together in Hawaii. After the Marine Corps I moved from my home town in Ohio to Wisconsin. Stevens Point is Jason's hometown and where he had many dreams of one day taking over his family business, along with so many other dreams for our future.

Even when life seemed impossible and we questioned ourselves, we always found the strength and love to work through it. Neither of us could ever give up on each other or our marriage. Our daughter and I have been cheated out of every Father's Day, having a father at her soccer games, having her dad to walk her down the aisle one day, and, most importantly, she was cheated out of his unconditional love, support and guidance in life.

Jason was not only my best friend and husband, he was my family. When my mother passed away 3 years ago, the same day I was diagnosed with cancer, leaving me with no parents, he was the one that was there for me during the most difficult times of my life. He was my rock. I could always count on his love. He drove 9 hours in the middle of the night to be my side during emergency surgery. He's the person I called when I had something to talk about, whether it was good or bad. He was always the person I talked to. He has been taken from me. During treatment I never had to question if Jason would leave. He loved Anaya and me unconditionally. He was a good person with such a good heart and was taken far too early from us. This is not how he deserved to lose his life.

Because of the treatment Jason received at the VA, the only family I had here, aside from my daughter, was him. I still do not know how we ever find peace, because in my heart I know he should be still here with us today. Anaya and I lost more than a

¹The prepared statement of Ms. Simcakoski appears in the Appendix on page 253.

husband and a father. We lost part of ourselves. A part that I do not know you ever get back.

With this, it is so heart breaking to know that someone with such love and passion for helping others has been taken from Anaya and I, and I truly believe in my heart that he would be here today with the proper treatment.

I have so many questions which I hope to find answers for.

I would like to understand how and why Jason's police reports disappeared. There are reports that he made to Dr. Houlahan, the Tomah VA, the Tomah Police Department, as well as the Federal Bureau of Investigations (FBI), regarding patients selling their prescriptions. These reports were made back in 2013.

Some of the patients were making so much money that they had saved enough money from selling their prescriptions to put a down payment on a house. Thankfully I have the voice mails and text messages between Jason and the officers, otherwise I am not convinced anyone would be listening to this point today. I would like to understand who is responsible for these reports, where they are and why no one did anything with the reports.

Additionally, when you are managing someone with addiction to prescriptions, or anyone, for that matter, once they are admitted into inpatient care, why do they still continue to receive the same medications by mail at their house? The same ones that they are receiving while at the inpatient facility.

I also have concerns about the way Jason was treated by the doctors as a patient. When he complained that his medication was making him uncomfortable one evening, he knocked on his physician's door. She opened it and slammed it shut in his face. He was not a prisoner, nor was he in boot camp any longer. He was a veteran who was willing to sacrifice his life every single day for each and every single one of us, including those treating him. And to know this is how they treat their patients is devastating and completely unacceptable.

Also living with Jason I was able to see the long-term impact of all the medication. I would see him falling asleep while he was eating. He would drive up on the median. He would slur his words when he was speaking. He would not be able to work sometimes for weeks, even months at a time. There were times he would sleep 18 plus hours a day. There were times he would not come out of his room for days and he would sleep all day. Jason did not even realize his behavior was so erratic at times, but there were instances where I would video record it and show him later so he would see what I saw.

I would like to understand how a doctor can prescribe 14 different medications and know which ones are working and which ones are not. When you have that many medications in your system, your mind is altered. At that point I question how a patient can even articulate to a doctor what normal feels like any more, especially after mixing and matching, in my opinion, experimenting with medication on our veterans, my husband.

I would also like to understand why alternative treatments were not tried for Jason. After years and years of prescription treatment, he was not rehabilitated. Does the VA only believe in treating ad-

dition by replacing one addictive medication with several others? I personally do not consider this success.

They did not just take away a person. They took away a hero, a friend, a husband, a father, a brother, and a son. Everywhere we go and everything we do, there are constant reminders of Jason's life and it is so unfair to him and every single veteran out there to think that is the type of treatment that is acceptable.

Veterans whom are willing to sacrifice their life for you, every single person in this room and in this country, they deserve so much more than second class healthcare. They should be proud to walk into a VA Medical Center to receive care. It should be world class treatment, not a last resort for those with no alternative healthcare insurance. This should be the last place costs are ever made.

I believe our family and every single veteran deserves answers and there should be significant strides made to rebuild the trust of all veterans. That they can trust that they will receive the highest quality of healthcare from the VA, regardless of the cost. I also feel we all deserve to know how to push for change effectively.

I say this with no sarcasm intended, but it currently seems that the only way to get anyone to do the right thing is to involve the media. I ask myself today, if it had not been for the reports on this story, if there would ever be any changes made at the Tomah VA. I would like to understand how processes can be put in place to ensure there is accountability without such extreme measures.

Chairman JOHNSON. Thank you, Heather. And I think I speak for all of us here, Heather, Anaya, and Marv and Linda, we are so sorry for your loss.

Ms. SIMCAKOSKI. Thank you.

Chairman JOHNSON. The next tragic story will be told by Ms. Candace Delis. She's the daughter of Thomas Baer, a 74-year-old veteran who passed away after waiting for treatment for over 2 hours in the Tomah VA Medical Center. Ms. Delis.

TESTIMONY OF CANDACE DELIS,¹ DAUGHTER OF THOMAS BAER, AUBURNDALE, WISCONSIN

Ms. DELIS. Thank you for the opportunity to be here today.

I realize that my father's death was not related to medications, but I believe it speaks to a broader issue of care at the VA.

Fifty years is a long time to keep a secret. My father, Thomas Baer, was drafted and proudly served in the U.S. Army until he was medically discharged with a service-connected mental health issue. Between the time he left the Army in 1965, until his death in January, 2015, he was treated off and on and hospitalized at several VA hospitals. One was Fitzsimons Army Hospital at Aurora, Colorado, which is now closed. Another was the St. Cloud, Minnesota, VA Hospital. The most recent and the last was the Tomah VA.

He was hospitalized and treated twice in the inpatient mental health unit at the Tomah VA. Once in 1970, shortly after he met my mother and again in 1982.

¹The prepared statement of Ms. Delis appears in the Appendix on page 256.

He and my mother remained silent about his illness, even keeping it from me until I was in my late teens in an attempt to protect me from the realities that they both faced daily. Until today, aside from me, my mother, and a few close friends, no one other than his doctors knew of his struggle, because there was, and still is, maybe to a lesser degree, a stigma that goes along with mental health issues. A stigma that causes feelings of shame, fear, and hopelessness. A stigma that leads to blame, discrimination, and misrepresentation in the media. That is why I have not spoken about this in detail until now.

My father was treated at the Marshfield Clinic Medical Center on Friday, January 9, 2015, for a bronchial infection. He was prescribed steroids as well as an antibiotic. Over the course of the weekend, his behavior had changed. He was restless, confused and dizzy. Symptoms that were related to his mental health issues and symptoms that could be triggered by the steroids. So on January 12, 2015, we tried to make an appointment for him to see his regular provider at the Marshfield Clinic. We were unable to do so because of scheduling. My mother and I discussed it with my father and he felt as though he needed to be hospitalized, so we called the Tomah VA. We explained the symptoms that we thought were mental health related as well as the symptoms of the bronchial infection, which included trouble breathing and the fact that he had chronic obstructive pulmonary disease (COPD). We were told that we could bring him down and he would be evaluated.

There is an important point that I would like to make. We have been questioned by cowardly, anonymous VA employees in Tomah on news websites and on forums—one of which hid behind the screen name TomahRN. These employees disingenuously ask, why did not you take him to a local hospital? Here are our reasons why. First, trust. Second, fear. And third, duty.

First, we trusted the VA nurse who told us to bring him after we told her his symptoms. We trusted her medical knowledge and training and believed she would tell us to go elsewhere if it sounded like his symptoms were life-threatening and the VA could not treat him there. We trusted that she was confident that the VA could treat my dad in a compassionate and competent manner after we drove 60 miles to get there.

Second, we feared the VA would stick my parents with the medical bill. When the nurse told us to come in, we were required to come in under implicit threat that my parents would bear the burden of enormous medical fees. You see, in the 1990s, my dad had a similar emergency. My parents made the mistake of seeing a community doctor with no prior approval for the emergency with the VA and my parents were stuck with the bill for thousands of dollars.

Third, and most importantly, Veterans Affairs has a duty to competently treat our nation's veterans in exchange for our veterans fulfilling their duty to protect our country. My dad was entitled to competent care and the VA had a duty to provide that. I would not be here today if the VA had fulfilled its duty to my dad.

I have thought long and hard about those anonymous public jabs at our grieving family from Tomah VA employees. Shame on you,

whoever you are, because our trust in Veterans Affairs and in you to fulfill your duty is what killed my dad.

We arrived at the Tomah VA Urgent Care at approximately 11 a.m. We checked in. I explained my father's symptoms and the urgency that he needed to be seen. It was not until nearly 2 hours later when he slumped over in the wheelchair he had been sitting in that we were seen. He was unresponsive for several minutes. While they were trying to speak to him, I kept telling them, I thought he had had a stroke, since his left side was limp and he was leaning in that direction and unable to speak. They told me he was fine because his vitals were normal. I asked them again to please do whatever tests they could do to see if he had suffered a stroke. I was told they were too busy, and since, at the time he was able to speak and respond, although barely, and not understandably, that they were going to put him in a room until someone was able to evaluate him.

They did an electrocardiogram (EKG). I had to help the technician fix the machine, because the paper had jammed and she did not know how to fix it, and a chest x-ray, but no tests relating to a stroke, even though I had asked repeatedly. Approximately 45 minutes had passed and my father stated he needed to use the restroom. The nurse got him up on the side of the bed. My mom and I went outside for a few minutes to give them privacy. When we came back in, no more than 5 minutes later, we walked into the urgent care to hear the nurse screaming for someone to help her. We could hear her at the end of the hall just past the nurses' station where there were other staff, but no one moved to help. As my mother and I ran down the hall, we came into the room to see my father half in the chair, half on the floor, completely unresponsive. His left side hanging limp, but worse than the first time. The nurse was trying to get under him to get him back into the chair. My mother was screaming and I went to get someone to help. Finally two other nurses came in and got him back into the bed.

According to their website, out of the 94 doctors and nurses, the Tomah VA has one doctor that is board certified in emergency medicine. This doctor is Dr. James Patterson, the doctor who was working in the Urgent Care that day and the doctor who treated my father. Dr. Patterson said my dad had suffered a massive stroke and told the nurse that a CT was needed. The nurse replied with, we cannot. The CT is down. Dr. Patterson said he would need to be transferred to another hospital because they were not able to properly treat him there. I asked about the clot busting drug for strokes, but he told me they could not administer the drug without first doing a CT scan.

They told us they were going to fly him to Gundersen Lutheran in La Crosse. A few minutes later they came back saying there were no helicopters flying that day, but they would not tell us why. It seemed completely strange, since it was a clear day with no wind. Then we were told he would be taken to La Crosse via ambulance. An ambulance that they were intercepting, that was originally on its way for another patient who was having a possible heart attack.

When we arrived at the emergency room in La Crosse, the doctors indicated that he should have been given the clot busting drug

in Tomah and that they could not understand why he was not, nor why he was not flown to the hospital. A CT scan was done immediately and surgery performed to remove the clot from his artery, but my father never regained consciousness.

Tuesday morning, January 13, my mother was told by a social worker at the hospital that the VA would be paying for all of my father's medical care at Gundersen Lutheran, as well as any rehab that would be needed, but my father never left the hospital alive. They did another CT scan on Tuesday evening. They indicated he had likely suffered another stroke, and had a brain bleed and that his brain was swelling. After long discussions with the doctors at Gundersen Lutheran about his prognosis, my mother and I decided to remove any life-sustaining equipment, and at 4:20 p.m. on Wednesday, January 14, my father died at the age of 74.

In 1982, when I was seven, I traveled to the Tomah VA Hospital with my mom to visit my dad at the inpatient mental health unit. We did this on several occasions, I am told, but I only have one memory. I remember being on an elevator inside the hospital with my mom and the doors opening between floors to a brick wall. Who knew that 32 years later I would be facing another brick wall of sorts, again at the Tomah VA.

We are left with so many unanswered questions, and the VA has been anything but transparent.

The fact that my father, a man who proudly served his country, sat for almost 3 hours in the waiting room of Tomah VA's Urgent Care department is completely unacceptable.

Had they done something as simple as a CT scan at Tomah, the outcome may have been different. My mother lost her husband of 43 years, her partner, and her best friend. My 10 year-old stepson lost his grandfather and I lost my father. The man who taught me love, compassion and honesty. The man who, no matter what, always had time for me, and the man whose words made me feel as though I could accomplish anything.

I am ashamed to live in a country where men and women are sent to fight wars where they suffer horrible injuries and mental trauma, and, when they return, instead of being rewarded for their service and treated with respect, they are ignored, neglected and left to die.

Like the other families here today, I am tired and I am grieving, but I will continue to fight for justice for my father and for other veterans. I want to do whatever I can to ensure that no other family has to go through what we have gone through. I want to be proud to be an American again. But without drastic and immediate change at the Tomah VA, I do not know if that is possible.

My family and friends have asked what we will do now. We will fight back—both in the courtroom and in the court of public opinion. This morning we filed an SF-95 claim with the VA and intend to sue, while getting the word out across the Nation. We are represented by a leading independent journalist and attorney fighting for veterans across the country. His name is Benjamin Krause. My dad's death will not go unnoticed and the VA's treatment of him will not be forgotten.

[Applause.]

Chairman JOHNSON. Thank you, Candace. Candace, again, we are so sorry for your loss. These stories are heartbreaking. I think everybody in this room feels that.

I just want to thank all the witnesses for your courage, for stepping forward, for coming here and telling your stories in such a public forum. It is not easy. I understand this. It is not easy to tell the story. It is not easy to listen to them. But I hope that America does hear this. I hope Wisconsin hears this. I hope the VA hears them.

Again, thank you for sharing all that. We will proceed to a round of questioning here. It will be 5 minutes. I do ask my colleagues to please respect the 5-minutes. I certainly will, so we can keep the hearing moving.

Candace, I would like to start with you. At what point in time did you see a doctor when you first came into the Urgent Care Center? How long did it take before a doctor was even present?

Ms. DELIS. A doctor was present after we had waited nearly 2½ hours, and then, even after dad had had the first stroke it was several minutes before a doctor came into the triage room. We were just in there with the nurse. So it was over 2½ hours.

Chairman JOHNSON. It is a very small facility, is it not?

Ms. DELIS. Yes.

Chairman JOHNSON. Did you ever see a doctor treating anybody else? Were there other emergencies going on?

Ms. DELIS. There were people that had come and gone since we had been sitting there waiting.

Chairman JOHNSON. Who is evaluating your father for stroke symptoms? Was it a nurse?

Ms. DELIS. It was a nurse. It was the same nurse that had taken his vitals an hour earlier and put us back in the waiting room.

Chairman JOHNSON. When you finally did see Dr. Peterson, did he express any shock that this had been going on for so long, or?

Ms. DELIS. It is Dr. Patterson.

Chairman JOHNSON. Oh, I'm sorry.

Ms. DELIS. That is fine. No. He had a nonchalance about him. He acted inconvenienced that he was taken away from whatever he had been doing previously.

Chairman JOHNSON. You were told he was going to be helicoptered after this 2½ hour, maybe 3-hour wait, helicoptered to Gundersen Lutheran, and then that did not happen?

Ms. DELIS. Correct.

Chairman JOHNSON. Can you just explain what happened there?

Ms. DELIS. Well, he had asked the nurse to get a CT and the nurse told him the CT was down. My mom had overheard someone in the hallway. He said, well, what about Tomah Memorial? And a nurse told him, we cannot send him there. And then they came back in and told us that they were going to Med Flight him to La Crosse. So we waited longer and then they came back in and said we cannot fly him. We are getting an ambulance. We are intercepting an ambulance from another patient and we will get you there via ambulance.

Chairman JOHNSON. Do you know why they cannot take him at the other Tomah facility?

Ms. DELIS. No. No one will answer our questions.

Chairman JOHNSON. We will try to get an answer to that. Marv again.

You said Jason had a 3-month stay. Was that for his drug addiction?

Mr. SIMCAKOSKI. Right, he was in there 3 months. Basically the doctor was going to try to change up his medications and, and she thought it would be best if he stayed right there while she was changing all the meds, just because of, what kind of reactions he would have and, and she wanted to see him, supposedly daily, as he was getting switched from different kinds of medications to others, which we thought were going to be less, obviously. Then after he died—we, we had no idea that he was on—I gave him his meds daily, but not when he went back into that 3-month period, and then when he came home for a couple weeks, I did not even realize that until after he died that he was on that high amount of meds.

Chairman JOHNSON. But he was being treated for drug addiction?

Mr. SIMCAKOSKI. Right.

Chairman JOHNSON. How many times did you talk to different doctors about your son's care?

Mr. SIMCAKOSKI. Well, my son had the first doctor who was there quite a while. And, I would meet with her and with my son, and, I mean, there was times that my son was set to go home where I would pick him up and he was all slurry yet. And, I would say, I do not think he's ready to be going back home. I think something is wrong here. And she said, well, he's fine. He's fine to go. And, one time I told her, I said, I see him and I see a lot of these other patients that are walking around like zombies here. Everybody looks half dead.

And I said, if he's so fine, why do not you let him drive your car in the parking lot. And she said, well, he's not driving my vehicle. But she said he was able to drive a vehicle. Well, he ended up getting a speeding ticket afterwards. And I think he went in the ditch one time where he fell asleep. And, I mean, he was not in no condition to drive, as Heather stated.

So, it seemed like the nurses and that, it seemed like they tried to help, but the doctors would not take advice from the nurses or the counselors. I mean, he would go into the group meetings, and the 28-day program, and, he did not get anything out of it because he was so medded up. He did not even know what was going on half the time. All he was worried about was getting his medications from the VA.

Chairman JOHNSON. So you are just saying the doctors were dismissive?

Heather, did you have discussions with doctors? Did you ever get any explanation?

Ms. SIMCAKOSKI. I did not have discussions with the doctors, but I would ask Jason, all the time why his behavior was so erratic and we would talk to Marv. He would include Marv on everything and Marv would talk to doctors, but we never got anywhere.

He was safer, in my opinion, in our home than he was in their care, because they consistently did the opposite of what we would—and what Marv would ask them to do.

Chairman JOHNSON. Thank you.

Chairman MILLER. Dr. Johnson, in your testimony, you mentioned that your refusal to fill several narcotic prescriptions written by Dr. Houlihan were the basis for your firing, is that correct?

Dr. JOHNSON. Yes.

Chairman MILLER. In your career as a pharmacist, how many times have you refused to fill a prescription?

Dr. JOHNSON. Those that were from the Tomah VA and one other prescription at my current facility. It was for a methadone prescription that was trying to be illegally prescribed for opiate withdrawal, which is illegal if you do not have a special license.

Chairman MILLER. And how many times were you retaliated against for not filling these prescriptions?

Dr. JOHNSON. Every time at the Tomah VA and essentially even the time at the current facility I'm at.

Chairman MILLER. You were retaliated at your current facility as well?

Dr. JOHNSON. Yes.

Chairman MILLER. Your testimony, you mentioned you were only at Tomah for a year?

Dr. JOHNSON. Yes.

Chairman MILLER. From July 2008 to June of 2009. Talk about your career before and after.

Dr. JOHNSON. I came to the Tomah VA Facility—I was actually a new pharmacist. I did my residency in Columbus, Ohio, at the VA there. I worked under a board certified pain specialist at that time. And I also worked in some chronic disease state management clinics and then I came to the Tomah VA as my first job outside of residency. After the Tomah VA, I did a short stint with a retail pharmacy of Walgreens for a few months. And then I sought to get back into the VA system in the Des Moines VA and I have worked there since 2010, working in their pain management clinic as well as doing Patient Aligned Care Team (PACT) med management as far as chronic disease state management.

Chairman MILLER. Mr. Honl, in your testimony you stated the system was slow to respond but quick to silence those who raised concerns. Can you elaborate further for us?

Mr. HONL. Just from the very moment that I blew the whistle and I came out publicly—I filed one morning and a few hours later I heard from somebody at the OIG, and they basically put an option before me. Put me on the spot and said, you can do this anonymously and then it will go directly down to the Facility and they will have to investigate it, but we will be able to more thoroughly investigate if you give us your name so you can give it to the chain of command.

And, of course, it is one of those crossing the Rubicon-type things. Once you make the decision to release your name publicly, then, especially in the VA culture, get ready for a wild ride. I mean, the circus is just beginning.

And it happened all the way from within my service line, and it just built from there. I mean, my initial complaints were just fraud and abuse and, trying to get somebody to look at it within my service line. And before I know it, everybody is telling me, do not go to Dr. Houlihan, who is the one I would have to jump over my serv-

ice line manager to talk to, because he retaliates and nothing gets done and he's been investigated over and over again.

And then Mario DeSanctis, well known that he was a rubber stamp. Do not go to him, because David Houlihan is the one who wears the pants in the Facility. So I was left with, OK, go to the OIG, but once I go to the OIG it goes down to VISN 12 in Chicago and then comes back down into the Facility for, basically for Dr. Houlihan to investigate himself. And just imagine where that goes. No where.

But that's what's been going for years in the Facility. It is not just me. I mean, Noelle talked about it and it has been going on for years and years where complaints are sent down instead of up to the people who can independently and objectively investigate.

Chairman MILLER. Heather, in your written statement, you questioned why alternative treatments were not provided to Jason. Did Jason ask for any alternative treatment?

Ms. SIMCAKOSKI. Jason did not ask for any alternative treatments, but I do not know anyone with an addiction to pain medication that is going to ask for a different treatment.

Most of them cannot say no. They are going to take whatever they get and numb the pain, whether it is with that same prescription or something different.

Chairman MILLER. Did the doctors ever offer something alternative to prescriptions?

Ms. SIMCAKOSKI. Absolutely not in my knowledge. They have never offered anything except substitution of medication.

Chairman MILLER. Candace, real quickly, because I only have just a few seconds left. But, if your family had not had to worry about being charged for going to a hospital other than Tomah, do you think you would have gone to another hospital or would you have gone to Tomah anyway?

Ms. DELIS. Absolutely. We live in Marshfield and we have the Marshfield Clinic there, and it is one of the better facilities in the State.

Chairman MILLER. Thank you.

Chairman JOHNSON. Senator Baldwin.

Senator BALDWIN. Thank you.

Heather, you and I have talked about the tragic loss that both you and your daughter Anaya must deal with because of Jason's death and you deal with that every day. But this treatment at the VA, started to effect your family a long time before Jason's death. And in your testimony you talk about the long-term impact of all the medications that Jason had prescribed to him. Can you talk to us about how Jason's personality and behavior changed from when you first met him and when he began the treatment at the Tomah VA.

Ms. SIMCAKOSKI. Absolutely. When first met Jason, his personality was magnetic. I do not know a girl in the world that would not have wanted to date Jason. We went down that road in the beginning. I mean, Jason was driven, motivated. When I met Jason, I truly believed our future was going to be limitless. I believed we would have the American dream. Everything would be amazing and wonderful and perfect.

And once he started receiving the treatment, the prescription pain medications, it slowly starting with him missing a day or two of work. Then he became irritable. It became to the point where he would not remember what he was saying, what he was promising. He started missing holiday events, special occasions because he could not get out of bed. He would—to the point where he would lay in bed sometimes for days, weeks at a time.

He did not want to do that, but he, he could not. He could not get up. He could not do anything. And there were events for our daughter Anaya that he would miss. Very special events. There were times he found it hard to get of bed sometimes to do very basic tasks for her.

He became somebody that, like, I did not even know. It was, like, Jason's body and face was there, but his personality changed so much, to a point where it created so much difficulty to where I would have to move out at times and move back in once medication would appear to make him normal, and then he would go back to the doctor. They would change his medication again. He would come back. It was constantly a roller coaster ride.

We always had hoped that he would be the same, but it just never was. He would nod off, fall asleep. He would fall asleep driving. He would fall asleep eating.

There were times he would get up in the middle of the night, turn on the oven and if I would not wake up, I would be afraid he was going to burn the house down. There was all kinds of erratic behavior. His appearance. Everything.

The side effects were just jarring. And I cannot imagine a doctor sitting across from Jason, looking at him when he first came and got treatment on that first day to the end, would not see those side effects, because they were clear to everyone around, not even just me, friends, and people in the community noticed it as well.

Senator BALDWIN. Marv, you raised Jason from a young boy to a proud Marine, and can you also speak with us about the changes that you saw occurring with Jason after he first began receiving treatment at the Tomah VA?

Mr. SIMCAKOSKI. Well, first of all, he went from about 180 pounds to 250 before the day he died. He had lost all his self-esteem. He did not want to be seen in public anywhere. He did not want to go in any place to eat. He would go to a drive-up window, because he did not want to go inside anywhere.

He worked with us in the family construction business. And, I mean, I would have to go check on him a lot of days because he would not come to work and I would have to get him out of bed and get him going and make sure he took his medication.

And when he first got back from the Marine Corps he was an energetic, motivated person. I mean, he wanted to go far. He wanted to make our business boom, bigger. He had a lot of great ideas. He was really smart. and he had a real nice personality. I mean, he could think of anything. I should say, not think of anything. He could actually do anything he wanted. He was real talented, but he lost all that. He lost his drive for anything.

And, like I said, his, his weight, I mean, he could not bend down good to tie his shoes or anything at the end. I had a hard time just getting him to function every day, but he was good for awhile. And,

like I said, then all of a sudden with all these different medication changes, he just went downhill real fast.

Senator BALDWIN. Heather, I wanted to ask you about the statement you made in your testimony regarding missing police reports. Can you recall any instances where Jason reached out to the Tomah VA Police Department regarding other Tomah VA patients attempting to sell opioid prescription drugs like OxyContin?

Ms. SIMCAKOSKI. Yes. I have text messages on one of Jason's old phones from 2013. He had gotten a different phone later on, but we still have that phone at my house. And when I go through it, there is several, I think there is over 160 text messages between the Tomah VA police chief and Jason where Jason did not want to be on drugs.

He actually said the temptation of the veteran trying to sell him the drugs was enough to make him want to turn that veteran in, because he could not resist the temptation. So he, actually was working with them. He was willing to actually do a controlled buy or wear a wire, or anything he could to get this veteran off the streets, *per se*. And at the end of the day, nothing ever became of it. Jason sent screen shots of the veteran to the Tomah VA Police Department, screen shots of the veteran offering to sell them drugs and nothing ever became of it.

Senator BALDWIN. Page three of the——

Chairman JOHNSON. Please stick to time limits here.

Senator BALDWIN. OK, we will follow up on the next round.

Chairman JOHNSON. OK. Thanks.

Mr. Walz, if you would also please also just reintroduce yourself. I am going to ask Congressman Abraham to do the same thing, actually.

Mr. WALZ. I am Tim Walz. I have served on the VA committee for the past four Congresses and I represent Minnesota's First Congressional District, which is the southern tier of Minnesota.

Once again, thank you all for your testimony. And, Mr. Simcakoski, it was painful to hear you to speak, and I hope it was painful for everybody in this room to hear it. Because, if that is what it takes to shake us out of this, because I am going to tell you something here that is this is all senseless and avoidable, we are hearing this, but I am going to tell you something that is probably really going to make you angry.

What you are telling, other people have been down this road, and folks have tried to implement that and that is what gets so frustrating.

Heather, could I ask, why was Jason being prescribed this? What did they say was wrong with him? Why were they prescribing him these drugs?

Ms. SIMCAKOSKI. His diagnosis would consistently change. One doctor would say one thing, another doctor would say another. It was consistently changing. One doctor would say he had one mental illness and the next doctor would say he does not have that. And they would say he had something different. It was always a changing story.

Mr. WALZ. And before he went in there, and as you noticed this, and I think most of us in this, there is a lot of folks sitting behind you and folks that understand this, that PTSD and other things

were starting to get to him. Why did he go in the first time? What did he hope to get from it? I mean, what did he want them to fix, if you will?

Ms. SIMCAKOSKI. His addiction to the pain medication.

Mr. WALZ. All right. And it is the pain medication. This is what I want to get back to again. And I want to read this for you, Marv. This is going to not make you happy.

My colleague and I, Jim Ramsey, had introduced and subsequently passed through Congress in 2008, VA Pain Directive 2009-053, calling for implementation of a system wide tiered pain management model that stepped up before we got to where you got. We went all the way through this and the Institute of Medicine, which is the gold standard for looking at this, this is what they said about the VA. They said the VA has done an excellent job in developing this comprehensive blueprint.

Did any of you speak to a pain care management person?

Mr. SIMCAKOSKI. Absolutely not.

Mr. WALZ. Do you know how many people do? Seven percent were on pain management?

Mr. SIMCAKOSKI. I did not even know there was one.

Mr. WALZ. Yes. You did not know there was one.

Mr. SIMCAKOSKI. No.

Mr. WALZ. And do you know what that person's job was supposed to be? To counsel you as the family and you with your right to sit there advocating for your son as an advocate to explain to the entire family and to the patient exactly what these things were.

And what the Chairman was asking about is, were there other alternatives? Like chiropractic care? Because if you can relieve the pain—the issue here is to get rid of the pain.

The issue is not—and be very clear. These drugs are powerful and important and helpful tools in the right dosages in the right situations. But the problem is, it is an easy way to get away from looking at the root cause of the problem, and you were never asked. You were never asked to get there.

I am going to ask you, Dr. Johnson, was that available? The pain care management? Was that available at Tomah?

Dr. JOHNSON. Absolutely not.

Mr. WALZ. So it was never implemented? Because here's what it says, unfortunate stepped-care model for the critical but unfulfilled component of their national pain strategy. So no one told you about it?

Dr. JOHNSON. No.

Mr. WALZ. And, Mr. Honl, you are convinced, even if it was there, that these guys would have gone around it anyway.

Mr. HONL. That is absolutely correct.

Mr. WALZ. Do you think, though, if it would have been there, it would have been part of the culture, that everybody who came in, like Jason, and they had to go through this with their family and to get all this, because I think each of these people hit on something very important. This sense of trust. We expect them to do the right thing. And do not get me wrong. The vast majority of employees at the VA want to do that, but the fact of the matter is, I am not a pharmacologist and I do not know pharmacological interactions and everything else. That is somebody else's jobs. And

their job is also why we put this in, to explain it to the most important person, that is the end user and the veteran. Nothing like that happened?

Dr. JOHNSON. No.

Mr. WALZ. At your new facility, is it being done?

Dr. JOHNSON. At our new facility, we do have a pain management, I guess, actual program, and we do offer alternatives, not just opioids. And we do try to get those patients under the 200 milligram morphine equivalent that they are on, but our interdisciplinary team offers chiropractic care, acupuncture. We have a physical therapist (PT) and occupational therapist (OT), psychologist. We have that whole team in place.

Mr. WALZ. Basically what the law asked to do?

Dr. JOHNSON. Yes.

Mr. WALZ. They have that in Minneapolis, but they have one chiropractor for 10,000 people. And they offer a yoga class at 2 p.m. on Wednesdays. Work that into your schedule.

Dr. JOHNSON. Yes.

Mr. WALZ. My issue here is—

[Applause.]

The issue is changing the culture on this. I would ask you, in your professional opinion, before my time runs up, and maybe ask the Simcakoski's on this. We cannot guarantee that would have prevented this senseless loss, but do you think it might have done something?

Dr. JOHNSON. I believe that the tragedies that happened to them were absolutely preventable.

Mr. SIMCAKOSKI. I do not know. I guess it may have helped. It just all depends on what the doctors did after that point. I mean, if they were not willing to work with the pain management team, then I guess it would not help.

Congressman WALZ. Just as a side note. It expired on October 31, 2014, in the VA. We have not been able to reauthorize it.

Dr. JOHNSON. Can I reiterate something here? Even if the doctors would not have agreed to work with the pain management team or done that, it is the pharmacist's job and their responsibility. The drug stops there. It comes out of their hands. They are the end gate. They should have stood up and said no. I would not have processed those medications that were prescribed to Jason. Obviously I did not dispense some that I did not feel were appropriate. Had somebody said no, even if the doctor decided whatever they want to do.

Doctors are not God. They have a license. They need to stand up and say no. And everybody at that Tomah VA should be held accountable for that. Not only the people that knew, but every single pharmacist that has dispensed one of those medications.

Those medications on the street, every single one came through the hands of those pharmacists. There needs to be accountability.

Congressman WALZ. Thank you. Thank you, Mr. Chairman.

[Applause.]

Chairman JOHNSON. Congressman Abraham, if you could introduce yourself real quick before you start questions?

OPENING STATEMENT OF CONGRESSMAN ABRAHAM

Mr. ABRAHAM. I am Ralph Abraham from Louisiana. You can probably pick it up from the accent. I am a practicing physician also, so I want to first say thank you for your moral courage. I see many of our veterans out in the audience. And acts of courage that are unbounded, I know you have performed, but moral courage, you have time to think what could happen when you testify like this, so thank you so much for showing up and speaking up and being here.

And, as a physician, you are right, Doctor, there still exists sometimes a God complex that we tend to endow, and shame on us for doing that, and kudos to you for saying no when you should have. If more of that would go on, then we would be more held accountable.

Like Senator Baldwin said, there is a sacred trust. And what more sacred trust between a doctor and a patient? To me it is even more sacred than a marriage, because a patient will tell me things that they will not even tell their spouse. So we are entrusted with so much of that and when we reach that, then, again, what a tragedy for, for you guys, because you all have lived it and there are no words to describe that.

My question to you, Dr. Johnson, and I think you mentioned in your opening statement, there were no routine urine drug screens, used to monitor drug use or abuse, is that correct statement?

Dr. JOHNSON. That is correct. And we were actually advised against urine drug screen testing because, in the face of a negative drug screen, doctors were being coerced or forced into still prescribing the medication, and then we were told we would be held liable for those medications that were being dispensed when something unfortunate happened, which is the case.

Mr. ABRAHAM. Yes. How crazy is that? I mean, we know if it is not in the urine, it is not being used.

Dr. JOHNSON. Correct.

Mr. ABRAHAM. It is being diverted somewhere. On the Opioid Safety Initiative, were any of the National Opioid Safety Initiatives that I am familiar with, were they implemented at the Tomah facility?

Dr. JOHNSON. When I was there, no. A lot of those Opioid Safety Initiatives did not come out until 2013.

Mr. ABRAHAM. Right.

Dr. JOHNSON. But even just one of the initiatives right now is to keep it under 200 milligram morphine equivalents per patient, which is still actually a fair amount of opioid.

Mr. ABRAHAM. That is a lot.

Dr. JOHNSON. The unfortunate part with Dr. Houlihan, that I believe even with some of the other providers, was that they were unwilling to implement the standard of care or try to bring those patients down. He absolutely refused to change some of those prescriptions, which does not make sense to me.

As, if you are going to give immediate release acting medication, why would you do that? Why would you not change him to something that could have been long acting that would have given better pain control or just try something different that would have given overall a better outcome for the patient. And that is why I

think the motives of him need to be questioned, because it does not make any sense, as a clinician, why he, he prescribed the way he prescribed.

Mr. ABRAHAM. And I think, Heather, it was you that said, we cannot measure—once we put more than one drug in a person's system, much less 14 or 15, no, we do not really know the interactions. Everybody metabolizes drugs differently. Everybody handles drugs differently. And there is no way to know that.

One thing the VA, as a system, Mr. Honl wants is continuity of care. That is what they tout is they want that veteran to come back over and over. But in Jason's case, especially, and a little bit in your case to, Ms. Delis, that when they saw the physical changes in Jason, the weight gain, the inability to perform work, the purpose of continuity of care is to—somebody say, hey, what is different here? And, unfortunately, and tragically, it did not work in this case, but that is the purpose.

So, again, like you say, Mr. Honl, it goes back to the culture of the system. And, the panels, everybody up here, we have talked and we understand that it has to be changed and it has to be changed quickly. We are behind the curve by light years and we need to catch up, so, again, thanks for your testimony.

I am most honored to be here.

I yield back to the Chair.

Chairman JOHNSON. Thank you, Congressman. Congressman Kind.

OPENING STATEMENT OF CONGRESSMAN KIND

Mr. KIND. Thank you, Mr. Chairman.

I am Congressman Ron Kind. I have the responsibility, the honor, really, of representing this district, as well as the Tomah VA Medical Center.

And Chairman Miller, Chairman Johnson, thank you for agreeing to hold this field hearing. This is not easy. These stories are not easy to be told or to be heard. And hopefully by having it here in the Tomah community it made it a little bit easier for all of you to share that.

I want to thank Senator Baldwin and my colleagues for joining us at this field hearing.

And, I was born and raised on the belief that we owe our veterans a debt of gratitude, as well as the benefits that have been promised to them that can never fully be repaid, but we have to try. And we can study all the reports, and look at all data, and all the trend lines, look at all statistics that we want, but there is nothing more powerful to us policymakers than these personal stories and how difficult it is for you to share them with us.

We share in your grief. We offer our condolences. But as I have had the chance to speak to all of you about what you have just gone through, I think there is an agreement at this witness table, and you have all done a great job testifying, that you want to do your best to help us ensure that no other veteran and no other family has to go through the type of pain and live through the type of tragedy that you just shared with us today. And that is the higher calling, I think, that we here as Members of Congress are responsible to ensure that our veterans are getting the care and the

treatment that they earned and that they deserve. And I think that is our promise to you that we are going to not rest until we can achieve that goal.

So thank you for testifying and for being here today.

Dr. Johnson, let me ask you, because I have limited time. I do have a few questions for you. Are we getting better? Is the VA system getting better at recognizing protocols of care or best practices or best evidence of medicine when it comes to the proper pain treatment that our veterans need right now?

Dr. JOHNSON. Overall I would like to say yes. After the 2013 VHA Directive came into play limiting those morphine equivalents, that has become a big thing. The pendulum on pain management is swinging from constant opioid medications to finding alternatives for patients. We are trying to implement those cognitive behavioral therapy programs for several of those veterans.

It is a slow change. And we have built a culture so far that we have been giving these patients this medication for so long, they are addicted—it is hard to bring those patients off of that medication. So it is going to take time for the whole entire culture and the facility VA wide to change, but I do believe, for the most part, and most of those VAs, this is occurring.

Mr. KIND. But you feel more confident that there are complementary forms of treatment, alternative forms of treatment, that can supplant the cocktail type of default button that seems to be pushed all too often with our veterans?

Dr. JOHNSON. Yes. And I would actually like to note that the American Academy of Neurology actually just posted that article recently and said that there is no long-term evidence to support chronic opioids in back pain, fibromyalgia, or headache pain. That is probably three fourths of the patient population that I see.

I am not doubting the patient's pain. What I am trying to say is that as the brain chemistry changes because of the drugs we are giving, we need to find ways to find other medications or other non-pharmacological ways to deal with that, because the brain can do that.

Mr. KIND. Here's what I have been having problems with the knowledge. I do not have a medical degree. I did not go to med school or anything, but my suspicion is every individual's pain threshold is going to be different. Therefore it's going to require a more individualistic type of treatment regimen for that veteran. How good are we getting at being able to provide that individual recognition to the veterans?

Dr. JOHNSON. I do think we are starting to get a little bit better. There are some sites that, would potentially even offer some genetic testing or those things to try to make sure that there are those who would absorb or break down the medication differently. Each patient's pain is definitely different. It's my job as the pharmacist on the team to make sure that we are prescribing the medications that are directly related or best to treat their pain. More often than not, it's not an opioid, unfortunately, for chronic pain patients. I mean, acute pain is a different situation, but I do believe that we are trying to individualize.

I will be honest, what I see a lot in my pain management team right now, unfortunately, is trying to deal with the mess that we

have made, and that we are dealing with a lot of addictions. We are not necessarily dealing with pain management.

Mr. KIND. Mr. Honl, let me switch to you. And thank you for your courageous effort in all of this, with the pushback that you encounter now, even threatening letters for defamation that you have had to endure, but you talk about the problem of not having the entities investigate themselves, but clearly we cannot send every complaint at a VA Medical Center outside for independent investigation. Are there lines that we can draw here that can help us where that's needed in certain circumstances and what needs to be dealt with internally?

Mr. HONL. Yes. I would just say, out of my experience, better staff work. I mean, if you are going to have a veteran staffer, they should probably be a veteran. They should probably be somebody, when they look at a report that they can identify that quickly.

In this case, really, the bigger problem is with the OIG, because that's their job, right? I mean, they are the ones who field complaints, along with you guys. And in a perfect world it would be the OIG that would be trusted, so they would not have to go to you all.

And so the problem is things just kind of snowball. You guys get hammered with more complaints, because nobody trusts the OIG, so you are overworked and you get these reports coming back and forth. I mean, balls are going to be dropped, right? It's just human nature.

So, again, I bring it back to two things.

No. 1, the big thing is accountability—whether it's the OIG or VA leadership. The VA is a big bureaucratic organization. And you have a lot of sacred cows and you have a lot of moving parts there. And when you have that type of a system, you have to have a system of accountability that's tightly controlled.

Out of my experience, when I was in the Army and I had to rate non-commissioned officers (NCOs), there was the best NCO, there was the worst one. And that's how you rated them. There's a bottom one. There's a top one.

When I was a sales manager in the corporate world, there was the best sales representative, the worst sales representative.

You know what it is in the VA? It has not gotten much press. 470 senior executives in the VA. Nobody below the line. Nobody. I mean, that's something to me that just defies logic.

And on top of that, they all get paid bonuses.

So until, there's accountability, until there's a ranking structure where you can go, here's the people that are below the line. Here are the people that need work or they need to go somewhere else.

The VA is hijacking itself and I do not think the proper response from the VA is to say, well, it's Federal workers. It's harder to get rid of somebody, blah-blah-blah. They are hijacking themselves. They cannot even rate who a poor performer is, so of course they are going to have a hard time getting rid of the poor performers, because they are all great.

Mr. KIND. Again, I thank all of you for your testimony today. We appreciate it. Thank you.

[Applause.]

Chairman JOHNSON. Congressman Duffy.

OPENING STATEMENT OF CONGRESSMAN DUFFY

Mr. DUFFY. First I want to thank Chairman Miller and Chairman Johnson for holding this hearing in Tomah. So often these hearings take place in Washington D.C., but the impact that the Tomah VA has had on this community and on our community, I think it's important that this hearing be held here in Tomah. And I am grateful for both of you for agreeing to have it here where so many people can attend and be part of the process.

I do see a lot of veterans here as well. I want to thank you all for your service and I know you are coming out not just to make sure we are holding the Tomah VA accountable, but you are here supporting your fellow families, who are very courageously telling their stories to this committee, and sometimes to the public for the first time, so thank you all for coming and participating.

I do want to make one note. We are hearing some of the horrific stories of some of the bad actors in the Tomah VA. I know a lot of veterans who do get good care here in Tomah and we have a lot of people who care for our veterans here in Tomah and they work their heart out every day to make sure they offer good care. And we cannot forget about that either.

But the stories that we have heard today are absolutely unacceptable. We should not have any of the stories of spouses, of daughters, of fathers of people who have passed away because of inadequate care.

But I do want to make that one note that it's not all bad. And I think it's important to note that.

This is, I will say, not the last step. This has to be our first step. I think our community, our delegation, the Veterans' Affairs Committee cannot let up. We cannot go home after today and say, this is the end. This is the first step in a long process to make sure we reform the VA so it works for our veterans, the men and women who have raised their hand to serve their country and are lucky enough to come home, to think that their lives would be risked in the healthcare system that was set up to benefit them, I mean, is absolutely unacceptable and untenable. And I think it's all of our jobs to make sure that this is the beginning of the end of poor care in the VA system.

Candace, I want to be clear. When your, when your dad was showing the first signs of a stroke, from the first signs—I know there was—you could argue, well, he had some other issues medically that could have been misdiagnosed on the phone, but when you made it here to Tomah and he became limp on the one side, how long was it from that point until you actually left to go to La Crosse?

Ms. DELIS. There was an hour, about an hour in between the first stroke and the second stroke and then there was about 30 to 40 minutes after the second stroke that we actually left to go to La Crosse, and then it was another over an hour to get to La Crosse.

Mr. DUFFY. So it's fair to say there was an hour and a half where he was showing the signs of having a stroke and care was not provided to him?

Ms. DELIS. That's correct.

Mr. DUFFY. He sat in the waiting room and then back in the emergency room?

Ms. DELIS. I would like to add that, in the waiting room, when he had the first stroke and he was slumped over, visibly slumped over in the wheelchair, my mom was screaming. The woman at the desk sat there and did nothing.

Mr. DUFFY. Did nothing?

Ms. DELIS. I got up. I ran to the desk. I said, you need to get a doctor. And then she finally got up, took her time, went down the hall.

Mr. DUFFY. Slow walk.

Ms. DELIS. And got someone. All the while we are trying to talk to my dad and get him to respond.

Mr. DUFFY. An hour and a half and then another hour to La Crosse?

Ms. DELIS. Yes.

Mr. DUFFY. Ms. Johnson, you had indicated there were—and we have not talked about this a lot. If you could try to answer this somewhat quickly. I have limited time. You said there were three people who really have not been talked about who died in—is it the parking lot here in the Tomah VA that are not part of the official reports, is that correct?

Dr. JOHNSON. Yes. There were three unexpected or unexplained deaths in the parking lot that spanned a 4-month time frame. I believe it spanned over the 2008 and 2009 period, so it would have been the winter months. Those are actually documented, you can see, in the concerns of the President of the American Federation of Government Employees (AFGE) that she had submitted to the IG and Capitol Hill, I believe, in 2009.

Mr. DUFFY. Do you know what those deaths were attributed to?

Dr. JOHNSON. No. At the time, I said this to VA Accountability Review Committee, that I was not there. I never saw the person in the parking lot. I am just saying that the Tomah VA is a small facility. I was told that they were Dr. Houlihan's patients. I do not know whatever happened to those patients. I do not know whether they were ever accounted for or whether there was an autopsy done.

Mr. DUFFY. Did you tell the IG about these deaths?

Dr. JOHNSON. Yes.

Mr. DUFFY. And just quickly, did you see the cocktail of drugs that Jason took before he passed away?

Dr. JOHNSON. On the MSNBC list, yes, I got to see it.

Mr. DUFFY. Was that a dangerous cocktail, in your opinion?

Dr. JOHNSON. Absolutely. I would have never ever dispensed them. The diazepam alone was 60 milligrams. The maximum is 40. Plus he was on temazepam. That's two benzodiazepines. Plus Suboxone and tramadol. You would never do that. Never.

Mr. DUFFY. My time is about to end, but I have five daughters myself, Heather, and I cannot imagine your daughter at 12 years old not having a father to walk her down the aisle. I think that was the most touching point. Little girls should have a dad and little girls should have a dad walk their daughters down the aisle when they get married and I am sorry for your loss and I promise

this panel will do everything we can to make sure that we remedy what has taken place here.

Thank you for your testimony.
Chairman JOHNSON. Congressman Pocan.

OPENING STATEMENT OF CONGRESSMAN POCAN

Mr. POCAN. Thank you Mr. Chairman.

My name is Mark Pocan. I represent south central Wisconsin, parts of six counties in the lower part of the State.

First of all to the family members, I do not know if I have the words adequately enough to express the condolences. I just want you to know that what you are doing today and what you are continuing to do, to talk out will definitely leave a legacy for your family members, because it's so powerful. We will get something done. And it's because of your courage and your speaking out that that's going to happen.

If I can just ask a quick question of Heather, it's all right.

Your husband, was he receiving the opiates because of a physical injury while he was serving? I am not sure if I quite understood that.

Ms. SIMCAKOSKI. No. Jason did not have any kind of chronic pain, so his receiving all of those medications was completely bizarre from day one.

Mr. POCAN. Did you think he was receiving the opiates because of post-traumatic stress?

Ms. SIMCAKOSKI. Yes. And other, maybe anxiety, things like that, but I am not a physician.

Mr. POCAN. Sure.

Ms. SIMCAKOSKI. But just applying common sense, when you are treating with an addict, even if there are other addictive medications that can be prescribed, even if they are not his pain killer of choice, there's popular street alternatives that were given to him that anybody with common sense would not give somebody with an addiction problem.

Mr. POCAN. Sure.

Ms. SIMCAKOSKI. Those medications for treatment.

Mr. POCAN. Thank you. And then a couple questions for Dr. Johnson and Mr. Honl.

So I cannot wait for the OIG and the VA, quite honestly, I have lots and lots of questions for them and, looking at that report, one of the problems that we have talked about is how do you get rid of the problem performers? But if you look at that report that we only got because a member of Congress had to make a formal request that they did not get otherwise, which I find outrageous, that if it had not been for that formal request we would not even have this to move forward, but the fact that—it's not just the employees that we need to get rid of, that, may have been around for a little while, but in both of your cases, you were around short enough that you had no protections. And I believe, if I remember right, Dr. Johnson, you were a couple weeks before your year was up where you might start getting those is when this happened to you. And, Mr. Honl, I think, same thing. Before you left you had a couple—within a week of you making an accusation, that's when you started getting the formal complaints.

Can you both just, one, just say if that is correct? Two, what recommendations do you have for people like yourselves that are watching this and able to blow the whistle, but, if you do, you risk your jobs? What could be improved to make sure you are getting the protections?

Mr. HONL. I have said this over and over. I think ultimately there are not any real whistleblower protections. Just by definition, when you blow the whistle, you are doing it on wrongdoing, and when there's wrongdoing, there's wrongdoers, and they are not going to like that you blow the whistle, so, real protections, yes. I mean, you mentioned a probationary period. I mean, that's been used here in this case. I was only there for 8 weeks, but, you are faced with what all whistleblowers are faced with. Do you hang in the system until the bitter end, until the OIG gives Dr. Houlihan, the investigation, and all of a sudden you do not have whistleblower protection and, I was a secretary, so maybe I did not cross all the t's or dot all the i's, and see you later, right, and have a termination on your record, or, do you do what I did and I resigned. I mean, I just got out of there.

And initially I was going to be like any other person that had been run out of there. I just wanted to forget about it.

Mr. POCAN. Sure.

Mr. HONL. And, since I was public, then I just had everybody out of woodwork coming to me with stuff as serious as patient deaths. So, yes, I mean, I do not really have an answer for it, other than, yes, the system needs to be examined, because one thing that—I think that there's a misperception in the public about Federal employees. And that's that they cannot be fired. Let me say, definitively, that is not true. OK? The 470 senior executives cannot be fired, because they are incompetent and do not know how to do proper ratings, but the people on the front lines like Dr. Johnson, on the front line, they get run out all the time. And a lot of the times it is in that probationary period, so.

Mr. POCAN. If we could just give couple seconds to Dr. Johnson to respond. Thank you, Mr. Honl.

Dr. JOHNSON. I was just going to say, I was taught, right is always right and wrong is never right, so, as a whistleblower, I guess no matter what kind of repercussions are going to happen, I was not going to be responsible for more deaths in the parking lot.

That being said, I believe that any legislation that was trying to be enacted and to protect those whistleblowers, and I believe her name is Ms. Flanz, I think, or something I read in the article that she said that the current system is fine and it works just fine. It does not work just fine. We are both examples of that and it only protects the management. So if anything can come of that and that portion of it, I would really like there to be legislation that actually passes and goes through that holds those people accountable. Even at the current facility I am at now, I have experienced it over again, and nothing happens to those people. They are allowed to continue to do that because they are in a position of leadership.

Mr. POCAN. Thank you.

[Applause.]

Chairman JOHNSON. I know I have lots of questions. I know my colleagues do too, but I want to be very respectful of everybody's

time, so we always hold the record open for 15 days. I would ask all the witnesses here to be willing to take questions from Members of this panel. It would be very helpful to us.

I certainly want to thank you for your thoughtful testimony, your thoughtful answers to our questions, your courage to tell these stories.

I think I speak for everybody on this panel. We are committed to doing everything we can to make sure these tragedies do not happen to others. And I just ask you to, please, continue to share your story. It's probably the best possible solution for the steps we can take to solve these problems.

So, again, thank you very much and with that I will call the next panel.

Thank you.

We have seated another panel. Again, it is the tradition of this Committee to swear witnesses in. I guess we have two main witnesses and other people who may assist, so everybody who may testify or assist in testimony, please stand and raise your right hand.

Do you swear that the testimony you are about to give before this Committee will be the truth, the whole truth, and nothing but the truth, so help you, God?

Dr. DAIGH. I do.

Mr. MALLINGER. I do.

Ms. CLANCY. I do.

Ms. OSHINKSI. I do.

Mr. DESANCTIS. I do.

Chairman JOHNSON. Please be seated.

Our first witness is Dr. John Daigh. He's Assistant Inspector General for the Healthcare Inspections of the Department of Veterans Affairs Office of the Inspector General.

Dr. Daigh is assisted by Dr. Alan Mallinger, Senior Physician within the Office of Healthcare Inspections of the Department of Veterans Affairs Office of the Inspector General. Dr. Daigh.

TESTIMONY OF JOHN D. DAIGH, JR., M.D.,¹ ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS, OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY ALAN MALLINGER, M.D., SENIOR PHYSICIAN, OFFICE OF HEALTHCARE INSPECTIONS

Dr. DAIGH. Good afternoon, Chairman Johnson, Chairman Miller and other Members of Congress.

Thank you for the opportunity to appear before you today in Tomah to discuss quality of care issues at the Tomah VA.

I am accompanied today by Dr. Mallinger. Dr. Mallinger has published over a hundred articles in peer review journals, held prestigious positions in psychiatry and pharmacology at several prominent medical schools and led research programs in psychiatry at the National Institutes of Health (NIH). He has worked in the office of Healthcare Inspections for the last 4 years.

Additionally he is currently on the Ethics Committee of the American College of Psychiatrists.

¹The prepared statement of Dr. Daigh appears in the Appendix on page 278.

In 2010, the VA and the Department of Defense (DOD) published the Clinical Practice Guideline: Management of Opioid Therapy For Chronic Pain. Our national review, VA Patterns of Dispensing Take-Home Opioids and Monitoring Patients on Opioid Therapy, which was requested by the Senate Veterans' Affairs Committee and published in May of 2014, includes the following statement: "Opioids are powerful medications that can help manage pain when prescribed for the right condition and when used properly. However, if prescribed inappropriately or used improperly, they can cause serious harm, including overdose and death."

This national review, which mirrored the timeframe of our work in Tomah, demonstrates that in 2012, VA providers were in general noncompliance with this guideline. Whether it be in the use of urine drug screens and followup visits, where we found they had 37 percent compliance with the guideline, or whether it be in the practice of refilling prescriptions early, 23 percent of the refills were filled early, the concomitant use of benzodiazepines and narcotic medications, which was used 92 percent of the time in the chronic opioid population, or ensuring that veterans with substance use disorder and chronic pain receive concurrent treatment for their substance use disorder and random urinary drug screening, with which there was 10 percent compliance.

The data in this report makes clear that VA as a system of care was managing this patient population very poorly.

The report states, the concurrent use of benzodiazepines and opioids can be dangerous because opioids and benzodiazepines can depress the central nervous system and thereby affect cardiac rhythm, slow respiration, and even lead to death.

The report also highlights the risk of liver toxicity as several combination medications include a narcotic and acetaminophen. And that a dose, among the chronic opioid user population, 45 percent of the veterans were prescribed at least one daily dose of four grams or more of acetaminophen, placing them at significant risk for liver failure.

Who are these patients?

One in 16 served in Operation Enduring Freedom or Operation Iraqi Freedom; one in three was diagnosed with a mood disorder; one in five with PTSD; one in seven with substance abuse.

My written statement reviews the timeline of events related to the Tomah administrative closure.

In summary, it was alleged that narcotic medication was being used as the primary treatment for PTSD, that specific patients were receiving poor quality of medical care, and that numerous patients were dying of narcotic overdose, that Tomah providers were contemplating the amputation of a veteran's leg as treatment for his pain syndrome and that there was inappropriate interference with the administration of the Pharmacy Service by Tomah management.

The administrative closure's first four pages deal with the steps OIG staff took to determine if these allegations had factual support. We reviewed numerous medical charts and peer reviews. We interviewed many current and former employees. We contacted the local Tomah police, the Milwaukee police, the DEA.

We pulled the e-mail of 17 employees. The OIG Office of Investigations examined aspects of these allegations. We found that the allegations that led us to Tomah could not be substantiated.

We did find examples of the failure to comply with DOD/VA Chronic Pain Guideline consistent with the national data discussed today.

Given that the data we collected did not support the allegations that led us to Tomah, and knowing that our national report would highlight the many deficiencies in VA provider's compliance with these guidelines, I chose to administratively close this report.

To ensure that the deficiencies we identified were corrected by VHA, Office of Healthcare Inspections staff met with the Director of Tomah, met with the VISN Director, and I was in frequent contact during this period of time with managers at Central Office, discussing the issues related to Tomah.

Both the Director of the facility and the VISN Director were familiar with both the individuals and the issues that we brought forward to them at Tomah. These leaders discussed the changes that had been instituted and future planned actions to address the deficiencies we identified.

The Office of Healthcare Inspections reviews aspects of hospital performance on a 3-year cycle and reports the results of each review in a Combined Assessment Review report. A review of medical center compliance with current VA stroke guidance is part of our current ongoing review.

Upon the completion of data collection and analysis, a summary report with recommendations will be presented to the Undersecretary for Health and then published.

I will be pleased to answer your questions.

Chairman JOHNSON. Thank you, Dr. Daigh.

Our next witness is Dr. Carolyn Clancy. She's the Interim Under Secretary For Health in the Department of Veterans Affairs. Dr. Clancy is assisted by Ms. Renee Oshinski, the Acting Network Director of Veterans Integrated Service Network 12, and Mr. Mario DeSanctis, the Medical Director, Center Director of Tomah VA Medical Center. Dr. Clancy.

TESTIMONY OF CAROLYN CLANCY, M.D.,¹ INTERIM UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY RENEE OSHINSKI, ACTING NETWORK DIRECTOR, VISN 12, VETERANS HEALTH ADMINISTRATION, AND MARIO V. DESANCTIS, FACHE, MEDICAL CENTER DIRECTOR, TOMAH VAMC MEDICAL CENTER

Dr. CLANCY. Good afternoon, Chairman Johnson, Chairman Miller, and Members of the Committees.

Thank you for the opportunity to participate in this hearing and to discuss the quality of care at the Department of VA, Tomah Medical Center. To be efficient, I will not repeat your introductions of Senator Johnson or my colleagues.

I want begin by expressing my profound sympathy to the families of the veterans we have lost here. The stories you have told today

¹The prepared statement of Dr. Clancy appears in the Appendix on page 286.

have been noted by others are profound and an invaluable gift to us about and we will use that to improve. And it's an invaluable gift to current and future veterans, so both those who are served by this facility and across our system and, I have a personal stake in this. My brother, my husband's brother has devoted his career to military service and is now served by VA and I am sure that's true for all of us in the room. If it's not us personally, we have family members.

So our commitment to you is that we will use this information to improve, now and in the future.

In addition, I also want to thank the whistleblowers who stepped forward. We heard their courage. It's at some personal risk. We heard that earlier. They refused to be silent when they observed problems.

Secretary McDonald, Deputy Secretary Sloan Gibson, and I have met with whistleblowers and have consistently emphasized that retaliation will not be tolerated.

Last I want to express our appreciation to multiple members of the Wisconsin congressional delegation for their input and inquiries.

VA is committed to providing timely, high quality care. We can and have to do better. We have significant challenges to overcome here in Tomah and we own them.

Unfortunately, unsafe practices in pain management and psychiatric care and reports of fear and intimidation have cast a dim light on care provided at this facility. And the bottom line is that there have been a number of failures. Failures to veterans, and, frankly, failures to the frontline staff at Tomah who work very hard every day. I want to assure you that as investigations are concluded, we will act quickly, decisively, and productively, with veteran outcomes in the forefront of all of our decisions.

I also want to assure you that we are not waiting for the completion of all investigations to make required improvements here and across the system right now. We are also supporting research, as I speak, to evaluate alternatives to opioids in the management of chronic pain. That's nonnarcotic medications, acupuncture, biofeedback, other kinds of treatments, and, frankly, we are optimistic that this work will also help all Americans suffering with chronic pain.

We are working internally to address these issues, and, as you know, are receiving assistance from outside of Tomah. VA Central Office sent in its clinical team review and that preliminary findings were released. That initial review identified gaps in care and failures to adhere to recommended practices, and we acted by disseminating a tool system wide that makes it far easier for clinicians to do well by veterans and to identify veterans who may be seeking narcotics from other facilities within the system.

The OIG, the Joint Commission, and the Drug Enforcement Agency have reviewed the Tomah facility and Wisconsin's Department of Safety and Professional Services are also investigating, and we welcome that.

We realize that we need to regain trust. It will take transparency as well as candid, honest, clear, consistent communications across the organization.

First is the veterans' trust. And the only way to regain that is to put the veterans first in every decision. The individual veteran's outcomes from their perspective is our true north.

We also need to regain the public's trust, as well as the trust and confidence of veterans' representatives, both in Congress as well as Veterans Service Organizations and other entities.

That will take time. And, frankly, it will take demonstration of results.

Last, central to any success is to regain the trust of the Tomah frontline employees and staff, the vast majority of whom are doing their best to serve their veteran patients every day.

During my visit to the Tomah facility 2 months ago, I met with many dedicated staff members who are bearing the brunt of these issues. I heard directly from employees here about their concerns and fears. And while investigations continue, it's imperative that we also focus on care provided to veterans we have the privilege of serving here at Tomah.

And, those employees have a lot to be proud of. In benchmarking with the private sector, the Tomah facility actually does very well in a number of areas.

So, in conclusion, you can expect that the Secretary, Deputy Secretary, and I will always put veteran outcomes first. And we will act swiftly. And when we have actionable information, we will act on it promptly.

These investigations are an opportunity to get to the bottom of any issues so that moving forward we can make sure that these preventable deaths are not repeated here or elsewhere.

But, mostly importantly, the reason I can be optimistic, is that the devotion, resilience and passion of the frontline staff here at this facility will help us overcome these challenges.

Thank you and I look forward to your questions.

Chairman JOHNSON. Thank you, Dr. Clancy.

Let me start with the last point being about regaining trust of the employees and also the point you made that we really need greater transparency and accountability. In terms of retaliation—first of all, how long have been at the VA?

Dr. CLANCY. A year and a half.

Chairman JOHNSON. A year and a half. What did you do prior to that?

Dr. CLANCY. I worked at the Department of Health and Human Service (HHS). I directed a research agency that focused on safety and quality of care.

Chairman JOHNSON. I will say in our communication and work with you, I have been very pleased with your cooperation, so I truly appreciate that.

Dr. CLANCY. Thank you.

Chairman JOHNSON. In your year and a half in your position, how widespread do you find this type of retaliation that you are witnessing and hearing about here in Tomah?

Throughout the VA? Is this really a very unusual situation or do you think that type of retaliatory behavior against other whistleblowers, because it sounds like it might be more widespread?

Dr. CLANCY. I do not think that we have celebrated negative feedback, uncomfortable feedback as a gift that it is.

It is a gift. If someone tells us very specifically, whether that's an employee, a patient, a family member, you could have done better or my family member would have done better if you had done this, that's the only way we get better. And I do not think that we have celebrated that enough.

Some of our facilities do. Some actually have awards for employees that identify near miss mistakes and so forth, but we are not good enough about that.

Chairman JOHNSON. Are you, actively working on cases similar to this in terms of the severity of retaliation that's being reported.

Dr. CLANCY. Yes, we are.

Chairman JOHNSON. How many?

Dozens? A couple?

Dr. CLANCY. I do not know the numbers. More than a couple, for sure. And I am not sure that we have identified all of the cases that need to be investigated. I am sure, as a result of this, having spoken with Dr. Johnson earlier today, that we will identify more that we did not know about, so I want to be very cautious in terms of using numbers.

I think you know that the Secretary instituted a single new team, the Office of Accountability and Review, specifically focused on investigating retaliation by senior leaders to employees.

Chairman JOHNSON. I appreciate that's. It's a very positive development here and we truly appreciate that.

Dr. Daigh was in charge, I think, of the report that was signed on March 12, 2014. The final report says, signed by Dr. Daigh, that I concur with the recommendation for administrative closure of this inspection. Was that closure, administrative closure, was that recommended by somebody? Was it a panel? I mean, how exactly did that work? Or did you decide that on your own?

Dr. DAIGH. My office routinely has a number of hot lines that we review. And if at the end of that hotline review we determine that the allegations are essentially not substantiated, then we may make the decision not to publish.

Chairman JOHNSON. So that's basically a team decision then? So you are concurring with the team of inspectors on doing the administrative closure?

Dr. DAIGH. Yes.

Chairman JOHNSON. OK. So, again, you base the recommendation on a team within the Inspector General's office?

Dr. DAIGH. So the folks that work with me, we sat down and decided that was the right answer.

Chairman JOHNSON. I want to ask some standard for substantiation of some of these charges. I am going to read from your report. "While we did not substantiate the allegation of abuse of authority, intimidation, retaliation when staff questioned controlled substance prescription practices"—OK, so you did substantiate that—"we did find that these are widely held beliefs and concerns among most pharmacy staff and among some other staff."

What does it take to substantiate claims of retaliation and intimidation? What would be the standard for substantiation, if that's not it? If everybody in the pharmacy is basically saying there's retaliation and there's a climate of fear?

Dr. DAIGH. So what we were looking for was clear evidence of somebody threatening a person or somebody saying in an e-mail or somebody making the statement, if you do not do this, then I will do that, so we were looking at evidence beyond a story. Something we could use to support the story.

Chairman JOHNSON. When you were before the Senate Veterans' Affairs Committee on Thursday, I asked you, when did you first find out about problems in Tomah. And you stated about 2011, although some of those anonymous letters that were brought to the fore, did you go back in time? I do not know if you were here when I was going through the timeline of when Dr. Houlihan has hired, how we have people, employees of the facility documented they were, back then, in 2009, already referring to him as the Candy Man? And this is Candy Land? And that they were already concerned about large quantities of painkillers being prescribed? I mean, were you aware of that? Was that part of your inspection?

Dr. DAIGH. So the short answer is no. I did not look prior to 2011. We got an allegation in 2011 that indicated along the same lines that we eventually turned into an administrative closure, but that review, I sent it to the VISN Director and said, these are serious allegations. Please look at these.

We get in the order of 40,000 complaints a year to the IG. My office gets in the order of magnitude 2,400 hotline complaints regarding quality of healthcare. So we have to have a way to address those complaints. So we have a group of us and we sit down.

And 10 years ago we had three to five complaints a week. Now we get more than 10 a working day.

I have a capacity to produce 50, 60 reports a year. So we, if we think the complaint is one we can take or should take, we do that. If we think it's serious, we send it to a level of leadership above the level of the complaint and ask them to respond back to us. We then read those responses back, and if they seem reasonable, then we end up closing that case.

Chairman JOHNSON. Thank you.

Dr. DAIGH. This is a similar process.

Chairman JOHNSON. By the way, that's a very helpful and interesting metric you just measured there or that you just mentioned. The number of complaints per day and the fact that it has risen dramatically, I guess that tells us something that Dr. Clancy has got a real challenge on her hands. Chairman Miller.

Chairman MILLER. Dr. Daigh, in your written testimony you state that given the totality of the facts at the time, the administrative closure was appropriate. So given the totality of the facts that are known today, would you make the same decision?

Dr. DAIGH. I think the issue is whether or not my discussions with VA leadership would have resulted in change. And I think, looking back, those discussions with leadership at all levels, Facility Director, VISN Director, VA Central Office, did not result in change. Change obviously needed to occur.

So if I were able to understand that change would not have occurred, I would have made a different decision. At that time I had faith that, that they would make the change.

Chairman MILLER. How has the experience changed the way the IG is going to handle similar investigations moving forward?

Dr. DAIGH. I think that certainly I have decided, and Mr. Griffin has decided that we will not administratively close hotline complaints. Further, they will all be published to the web.

I think the broader issue of the volume of work is an issue that we need to discuss with the committees in terms of how we communicate the issues that are in front of us, the locations of those issues, so that you understand what we are doing and similarly the VA understands what the issues are.

Chairman MILLER. I was troubled by Mr. Honl's allegations that an official from the Medical Center instructed him to not give files to anyone, especially the OIG. Were you aware of an effort by the leadership at Tomah to keep information from your investigators?

Dr. DAIGH. No.

Chairman MILLER. So how can you be sure that during your initial investigation your investigators had access to all of the information that was needed to conduct a thorough investigation?

Dr. DAIGH. When complaints are anonymous we sometimes have a hard time figuring out exactly who the complaint pertains to, so what we often have to do then is take a look at patients, for example, those who are in a group of patients receiving high doses of narcotic or a panel of patients that were under a certain set of circumstances that are described and we have to go through and check a sample of those patients. So we relied on reading e-mails that they did not have the ability to withhold from us. We relied on sampling charts that they did not have the ability to control. So I think we did everything we could to try to get the right answer and the right data.

Chairman MILLER. Dr. Clancy, we heard about the gentleman who had the stroke, that clot busting drugs were not administered because they could not get a CT scan. I mean, is that typical protocol that you do not administer that prior to them going through a scan?

Dr. CLANCY. Yes. The reason for that is that there is essentially two ways you can have a stroke. One is a clot, in which case the clot buster would be a really good idea. And the other is that you are actually having a hemorrhage, in which case that would be the end. So you actually need to know from a CT scan what's happening.

The CT scan was down at Tomah that day for preventive maintenance, and it's my understanding that the patient should have been sent to Tomah Memorial.

Chairman MILLER. And why was the patient not sent to Tomah Memorial?

Dr. CLANCY. I do not know, and we need to find that out.

Chairman MILLER. And what are you doing to find that out?

Dr. CLANCY. I know that there is an IG investigation ongoing now and I am also trying to work across the system to figure out—we have the bottom line is it's hard to get clot-busting treatment in Tomah, Wisconsin, regardless of where you get care. If we had gotten the CT scan, we could have gotten that, but we have the capacity to actually make this available virtually across our system and that we can make happen.

Chairman MILLER. Is it they cannot get the clot-busting treatment at the VA in Tomah, or they cannot get it in Tomah?

Dr. CLANCY. It's my understanding that there is not a stroke team at the local community hospital. I have not verified that, but that's what I have been told.

Chairman MILLER. What is the normal maximum—normal. What is the maximum dosage of opioids for pain that is effective for chronic pain? I had a doctor tell me that there is a level at which more does nothing to help stop the pain?

Dr. CLANCY. I would actually need to consult Dr. Johnson here for a more technically correct answer. I know that right now we are working to keep it below the 200 morphine equivalence dose per day.

Chairman MILLER. And what I understand, that is if it is being used for mental health purposes?

Dr. CLANCY. No, that is not used to treat mental health disorders. That is used to treat pain.

Chairman MILLER. OK, well I—

Dr. CLANCY. And it gets confusing, because many of our veterans have both chronic pain for a variety of reasons, as well as other mental health disorders, but morphine is not being used to treat mental health problems.

Chairman MILLER. But that is what Jason was being treated for. He had no chronic pain.

Dr. CLANCY. Well, what I heard his wife and dad say, and I have not looked at his records, although I know there has been a thorough investigation, was that the diagnosis kept changing.

In general, narcotics are not used to treat mental health disorders.

Chairman MILLER. I believe, and I will go back and check the record, but I believe she said he did not have chronic pain issues.

And, and my question is, I was told that basically anything above 50 milligrams, there is a question as to whether or not it is effective. And my question is, if you are using it for psychotic purposes, for some type of mental health, you are talking about 200 milligrams, so you are giving somebody something that is highly addictive.

Dr. CLANCY. Well, I think Dr. Johnson said it well when she said that in some ways we are actually treating the problem that has been created by overuse of these medications, so we have people whose tolerance levels are very high and we need to—

Chairman MILLER. Well, how about we do not take Dr. Johnson, because she is not on the panel.

Dr. CLANCY. Yes.

Chairman MILLER. How about Dr. Clancy?

Dr. CLANCY. Sure.

Chairman MILLER. On the record.

Dr. Clancy. Yes.

Chairman MILLER. And talk about it.

Dr. CLANCY. I was just being respectful of another discipline. Forgive me.

So I do not know the specific number at which you can say, beyond that, it does not work. I know that many of our veterans are on doses that are too high. I am pleased to say they are coming down, but they need to come down faster. And, very importantly, what I am almost more worried about is the fact that they are on

narcotics in combination with other medications, like Valium, the benzodiazepine group, which can put them at very high risk of adverse effects.

Chairman MILLER. And real quick. We heard today where people have lost sons.

Dr. CLANCY. Yes.

Chairman MILLER. They have lost husbands. They have lost fathers. We even heard a lady say she's lost her country. She is ashamed of her country because they have let her down. I hope that sinks in at the VA.

Dr. CLANCY. It certainly sunk in for me and I will make sure that we honor their experience by committing to do a lot better.

Chairman JOHNSON. Thank you, Mr. Chairman. That point that was well worth the few extra seconds.

Chairman MILLER. Thank you.

Chairman JOHNSON. Senator Baldwin.

Senator Baldwin. Thank you.

I wanted to start—I meant to do this at the end of the last panel, but to offer to both committees, testimony that was prepared by Lin Ellinghuysen, the President of the American Federation of Government Employees¹ here, and also Jason's mom, Linda Simcakoski, prepared written testimony² for our committee.

Chairman JOHNSON. Without objection, so ordered.

Senator BALDWIN. So the VA's current investigation into the Tomah VA began this January, and it is looking at a number of issues—prescribing, retaliatory environment, the deaths associated with the Facility.

A recent media report revealed that employees at the Tomah VA had called local law enforcement more than 2,000 times seeking help with cases of battery, burglary, an attempted kidnapping, and 24 unexpected deaths. And you heard that in the testimony also in the first panel.

Dr. Johnson stated that there were three unexplained deaths in the Tomah parking lot and that all three were patients of Dr. Houlihan's.

So, prior to the current investigation, did the VA ever investigate these allegations, including reports of 24 unexpected deaths and the deaths that Dr. Noelle Johnson says took place in the Tomah VA parking lot?

Dr. CLANCY. I am going to ask Ms. Oshinski if she has more information on that.

Ms. OSHINSKI. I believe there have been a variety of investigations over the years, although, Senator Baldwin, I would have to say they were probably case specific. I would also say that I was stunned by the numbers and was not aware that there had been as many as you had mentioned.

Senator BALDWIN. Well, I ask that you include all of those in your investigation moving forward.

Accountability is an essential piece of the VA's investigation into Tomah. This investigation will rightfully be judged in part by whether those who are found responsible for wrongdoing are held

¹The prepared statement of Lin Ellinghuysen appears in the Appendix on page 295.

²The prepared statement of Linda Simcakoski appears in the Appendix on page 307.

accountable. The veterans who have lost their lives and their families deserve no less.

And so far, Dr. Clancy, your review has resulted in some remedial administrative action against responsible VA employees, including Dr. Houlihan, but let me be clear. It is my expectation that these are merely first steps. And so I would ask you to please provide the committees with an update on all administrative actions taken to date and can we expect additional discipline and when?

Dr. CLANCY. I do not want to prejudge the process, so I want to be very careful about what I am going to say. What I released before was the first phase of a clinical review. The administrative reviews, which is looking specifically at retaliation is ongoing.

There is also a second phase of the clinical review, and I think that there will be additional actions, but that's all I am going to say about it right in this moment.

But I commit to you and other committee members and members here that we will let you know about that promptly when that takes place. We are not intending to make this many months or even many weeks. But we want to make sure that the entire process is fair and rigorous and will withstand appeal.

Senator BALDWIN. My office, and it sounds like other members of this panel, recently learned that Dr. Houlihan was the subject of a wrongful death claim resulting from the tragic death of Kraig Ferrington, a U.S. Army veteran, back in November 2007. And most disturbingly, the claim reports that the veteran who is under Dr. Houlihan's care died from drug toxicity. This is the same cause of death of Jason Simcakoski.

In other words, more than 7 years ago Dr. Houlihan and his inappropriate treatment practices were implicated in the death of a Wisconsin veteran, and last August Jason passed away from the same cause. How did the VA investigate this death and Dr. Houlihan's treatment at the time or since? And I am referring to Kraig Ferrington.

Dr. CLANCY. Hold on.

Ms. OSHINSKI. Yes.

Dr. CLANCY. At that time there was a malpractice claim made against the VA, and it was initially denied. And then appealed and a settlement was made. When that happens, all practitioners involved in the care of that veteran are reviewed by a centralized office of medical and legal affairs to determine whether they have met the standard of care.

And, as it happens, about 40 percent of the time the practitioners are deemed not to have met the standard of care. In this case, Dr. Houlihan and a physician's assistant were both considered to have not met the standard of care. And at that point, the next step is to report the two to the National Practitioners Data Bank.

Dr. Houlihan appealed that decision and it was upheld. So he was not reported. So there was an investigation. I know that some of you have actually had the opportunity to review the specific details on camera. That is what I know right now.

Chairman JOHNSON. Congressman Walz.

Mr. WALZ. Thank you, Chairman and thank you all for being here and your service to our veterans. Certainly no one questions our commitment to our veterans.

And, Dr. Daigh, you and I go back quite a ways too and you know that my issues with your staffing issue goes back to 2007. The need to have an impartial, fair, and accurate IG is absolutely imperative to the system. So I understand that. And I also understand you have to triage cases, but I am grateful for the change of policy on the administrative closures, just to let us know. It's another eye. And, again, it has been said by the Senator, having the press, they are another eye. They are partners in this. And I know you view it that way.

Dr. Clancy, also I thank you for your service. And you have heard me say very often, I am the VA's staunchest supporter and harshest critic when they need to be.

Just a couple things for me. Do you need us to reauthorize the Pain Management Directive? The one I was speaking of—2009-053, that expired in October, or can you do that?

Dr. CLANCY. We can do that and we are also working with new directors from the DEA in terms of how often prescriptions can be written and, how long they can be written for, and using that to tighten up even further our diversion policies and the ability to take back drugs that people are not using, because that is an important source for the community. I do not think that we need legislation, but I certainly would welcome your demanding regular reports, because I will be.

Mr. WALZ. Is the step care model, has it been implemented?

Dr. CLANCY. It has been implemented, but probably not as consistently as it could have been. I have just mandated last week that across the system we implement a system called Academic Detailing, which actually works with each frontline clinician and their specific panel of patients to help them customize care and solve problems.

As I think you have heard from Jason Simcakoski's family, a lot of times veterans do not necessarily want to go down this road, and may even get angry, so it takes some skill to help them get to a better place. And we have people who are quite skilled at teaching people how to do that. We need to make sure that happens everywhere.

Mr. WALZ. I think that is an important point you bring up, and it is certainly in the private sector also. There is about 25 percent of Americans going through this. And the Opioid Safety Initiative (OSI) that is being implemented, and this is very controversy, pain contracts.

And I think members up here will tell you this. We receive a large number of calls to our office of veterans who were pulled away from these and either for pain management or for the pain of addiction withdrawal that comes afterwards—

Dr. CLANCY. Yes.

Mr. WALZ. Is equally dangerous. And so, to get this right, this is a national dialogue and things that have to be put into place. The question I would ask is, how are you handling the folks who are initiating this?

And I ask you this because many of my veterans, because your pilot program is in Minneapolis on the OSI, and I am getting those calls from veterans. How are you handling the soft landing for these folks that are coming down from the addictions?

Dr. CLANCY. Well, first of all, we actually actively discourage, it is inappropriate for people to simply say to a veteran you are done, if they have been taking these medications for awhile. That would be instant withdrawal for some. The one thing that we are checking on and using our new tool as a way to do this is to make sure that people are not making the reports look better by actually forcing new patients to make that very hard landing. But it is a tough journey.

Now, on the other side of it, there are people who could not be more appreciative that they do not need these drugs any more, and so forth. And I think that we need to give a louder voice to them, but I try to watch both sides of that.

Mr. WALZ. I look forward this. I think you bring up a good point. It is the outcomes that we care about. I am very interested in working with you on maybe some reportings that come out of this, because from us to micromanage, and I think you saw what happened is, is that we got together. We passed a pretty good bill working with folks, but if it does not have the outcome—if I have a father here, it did not work. And so I have to figure out how it works.

I am also going to say, in preparation for this hearing, I went to, like, the wholesalers, McKesson, and some of those, and worked through them on how this whole thing works in the private sector, how the wholesalers get it to the pharmacies, how they retail it out and the State prescription drug monitoring system. If I get a prescription written here and I get it filled, what happens when I drive back to Mankato? Can I fill it again or will that red-hot when I try and do it?

Dr. CLANCY. We are working with the State prescription drug monitoring programs in 20 of the 49 States that have them. And we will be getting to the 50th. We had an internal issue about differences of opinion about whether it meant, whether we could share the information in a way that did not violate our security policies. We are working through that right now.

Mr. WALZ. Good. And that is the one I wanted to work with you on. I think this just makes good sense. It is the right way to do it. It is an extra check and it makes sure that these families said that we are not filling multiple prescriptions and they end up on the street.

And, Dr. Clancy, you and I have always had a very candid and good working relationship. This is just for me, a suggestion on this and I am thinking of this as a father. Review Jason's file. Just let his dad know you looked at it. I do not speak for him, but I would want to know as a father.

I yield back.

Dr. CLANCY. Thank you.

Chairman JOHNSON. Congressman Abraham.

Mr. ABRAHAM. Yes. I went to the Tomah facility this morning and did a tour, and you are right, Dr. Clancy. Everybody, or, most everybody that I came in contact with was motivated, generally seemed to care, but we certainly have a problem embedded within not only Tomah, but the VA system. And my question to you, in the VA system in toto, is there a protocol or a requirement for urine drug testing, prescription monitoring, training, having the

patient come back every month to receive a narcotics prescription? Is there anything like that out there?

Dr. CLANCY. There is a guideline that we jointly developed at the department.

Mr. ABRAHAM. It's not required?

Dr. CLANCY. Well.

Mr. ABRAHAM. I am saying—

Dr. CLANCY. I am just struggling with the word.

Mr. ABRAHAM. As a physician, if I know that my prescriptions, narcotic prescription that I am writing will be monitored, if I know that I am required to get a UDS on that patient, if I know that that patient is supposed to see me every 30 days in order to get 60 or 90 narcotics, then I need to check those boxes, and that's my question.

In the VA system, is there a required protocol in place for those physicians?

Dr. CLANCY. We have a required protocol in place. We also recognize that an unexpected result on a urine drug screen can mean a couple of things. It could mean our worst fear, that they are not taking the medications and selling them on the street. It could mean that they are only taking them intermittently.

So the first step is to actually have a conversation with that veteran and then up the frequency of those drugs.

Mr. ABRAHAM. Exactly, and you and I can get into the we as—

Dr. CLANCY. Yes.

Mr. ABRAHAM. As to what one UDS over another one means, but, overall, I think it's a good monitoring system—

Dr. CLANCY. Yes.

Mr. ABRAHAM. For narcotic abuse or use or diversion. So I guess the answer is right now there is not a required protocol out there, is that a fair statement?

Dr. CLANCY. There is a clearly specified protocol. I think it is fair to say it has been encouraged. It is now being mandated.

Mr. ABRAHAM. Thank you very much.

Dr. DAIGH on your report, you gave some objective data. Thirty-seven percent of the physicians did not adhere to the guidelines. Twenty-three percent got early refills.

If objective data is not being used in your determination that some of these claims are unsubstantiated, what did you use to have a conclusion on your report? I mean, I am looking at objective data here that is pretty damaging.

Dr. DAIGH. That's correct. So what I am saying is that the people, the providers at Tomah were no better than the general population in terms of following the guidelines. They did not follow the guidelines. That was the point we made to the Director and the VISN Director in our report.

The specific allegations that led us to Tomah, we could not support. I realize there may appear to be a distinction or a contradiction there, but we were forced to write allegations fairly narrowly, so that we can actually try to understand what is going on. And so we did not find, for example, that they were trying to cutoff a gentleman's leg because he had a pain syndrome.

And when you get to some of these allegations that are made, for example, the allegation that a certain provider threatened that

there will be retaliation if a drug sale was not stopped or there was not some action taken to break up a drug sale, when we actually get right down and we push it, we find someone who previously would say that they supported that allegation, we find that they melt away and they would not provide that allegation. So I pushed very hard to get facts to support the allegations that I listed in my oral statement, and I just could not get what I needed.

Mr. ABRAHAM. Dr. Mallinger, you and Dr. Johnson are the experts, certainly, in this field in this room. Do you, having written many articles and studied this,

I am sure, most of your life, do you have a recommended protocol for opioid or benzodiazepine use for chronic pain?

Dr. MALLINGER. Well, again, I am a psychiatrist and I would not portray myself as an expert on the use of opioids for pain management, but as a physician I certainly have some training along those lines.

Psychiatrists who are treating pain in their patients, along with psychiatric disorders, have a pretty difficult job. And the truth is that every patient is a little bit different. And it becomes very difficult to write any sort of universal guidelines.

I think the question was asked before, is there a maximum effective dose for opioids?

The truth is that as people use opioids over a period of time, I am sure you are aware of this, they develop a pattern of tolerance and the drugs become less effective. And in order to get the drug to work, physicians find themselves increasing the dose. And that may work for awhile. It may also be lead to what we call hyperesthesia, where they can actually make the pain worse or produce other kinds of pain, so it need to be worked out on the level of the individual patient.

Pain can be an exacerbating factor for psychiatric illness. Someone who has bipolar disorder, for example, if you introduce enough pain into the equation, it may trigger mood episodes. It is very hard to come up with a universal recommendation is what I am saying.

Mr. ABRAHAM. I yield back.

Chairman JOHNSON. Congressman Kind.

Mr. KIND. Thank you, Mr. Chairman.

Thank you all for your testimony here today.

Dr. Daigh, you were the lead person on the OIG 2-year investigation with the Tomah VA Medical Center, is that right?

Dr. DAIGH. That's correct.

Mr. KIND. That was 2012, 2013, roughly?

Dr. DAIGH. That's correct.

Mr. KIND. That led to a report that was concluded and closed out in March 2014, is that right?

Dr. DAIGH. That's correct.

Mr. KIND. Mr. Chairman, I would like to submit for the record a copy of that report,¹ if it has not been already.

Chairman JOHNSON. So ordered.

¹The report referenced by Congressman Kind is available at www.va.gov/org/pubs/admin-reports/VAOIG-11-04212-127.pdf.

Mr. KIND. After you had concluded and closed out that report, did you send a team to Tomah VA to brief them on your findings, as well as recommendations to be implemented?

Dr. DAIGH. We met on the telephone with the Facility Director and went over the report and recommendations.

Mr. KIND. Are you reasonably confident that they had moved forward on implementing the recommendations that were contained in your report?

Dr. DAIGH. Yes, by what they told us and what sounded reasonable. We met on a separate occasion in Washington when the schedules worked to meet with the VISN Director and that gentleman told us similar things about what they had done to make changes at Tomah.

Mr. KIND. Director DeSanctis, you were the Acting Director at Tomah VA at the time, is that right?

Mr. DESANCTIS. Yes, I was.

Mr. KIND. And based on a previous meeting that I had with you and your management team, you assured me that you took the recommendations in this report and started implementing them immediately during the summer of 2014, is that right?

Mr. DESANCTIS. Yes. In fact, we had already worked on corrective action plans in instituting the recommendations, even before we got the report. We actually got the report at the end of June, 2014.

Mr. KIND. Was there anything in any of the recommendations that you disagreed with? That you decided not to move forward on?

Dr. DESANCTIS. No. It's just that it made it very difficult for me, though, as a Director, because there was nothing in the report that indicated that there were any patients at risk, based on what was going on, or whether or not the standard of care had been met.

Mr. KIND. Well, when I showed up in your office in the summer of 2014, this is shortly after the Phoenix story broke and I came and was asking for information, just to assure ourselves that Wisconsin was not in the same type of situation, and also asking of any potential problems, and at the time you did not talk about this report to me at all. You did not reveal that it had been done, that you had been briefed or you were going forward with the implementations, but you also indicated that you were instructed not to, is that right?

Dr. DESANCTIS. Yes. I was instructed by the lead investigator that was in contact with me to not distribute copies of this internal document to others.

Mr. KIND. Did they give you a reason or explanation why?

Dr. DESANCTIS. No, they did not.

Mr. KIND. Dr. Daigh, you cannot imagine how frustrating this would be from our perspective. I mean, in part, your 2-year investigation was precipitated based on an anonymous letter that my office received. And when I read through the allegations, I felt they were serious enough from Mr. Honl's point, to not just to report it to the Tomah management team so they investigate themselves, but it went directly to the OIG, which led to the 2-years. You guys did it. You concluded the report. You closed it out and you did not publish it.

And I am glad to hear today that you have taken action now to publish on your website all future reports of this nature, but does that also include notification of the appropriate congressional offices too when you finish reports?

Dr. DAIGH. Yes, sir, it does. So if we are aware, and we try to keep accurate track of when you, for example, send us a letter, we would call that a congressional hotline, and we traditionally come back and go to a Member of Congress, whether it is an admin closure or not, and report the results of the report, so that is our past practice and that would be our future practice.

Mr. KIND. Because we have a communication problem that needs to be worked out.

Dr. DAIGH. I agree.

Mr. KIND. It is a serious one, whether you are going to be facing more panels like this in the future with unpleasant questions.

Now move onto a different topic. OIG also finished a report dated May 14, 2014, on healthcare inspection, VA Patterns of Dispensing Take-Home Opiates and Monitoring Patients on Opioid Therapy. Are you familiar with that?

Dr. DAIGH. Yes, sir.

Mr. KIND. Dr. Clancy, you are shaking your head too. You are familiar with it?

Dr. CLANCY. Yes.

Mr. KIND. You have been moving forward on recommendations systemwide?

Dr. CLANCY. Yes.

Mr. KIND. Based on this? Earlier this week, I, along with Representative Reid Ribble of Wisconsin had introduced legislation, the Veterans Pain Management Improvement Act, in part based on recommendations for the establishment of a Pain Management Board at the VISN centers. Have you had a chance to look at that legislation? Do you have any opinion?

Dr. CLANCY. I have and I actually think it is terrific. I would have one request, which I think would be very much in the spirit of this bill. I would hope that at least two members of that Board would be veterans or family members.

Mr. KIND. Yes.

Dr. CLANCY. Because I think that voice would be incredibly important.

Mr. KIND. It is part of the recommendations in the legislation that veterans and also family members, so that we get their direct input on pain management practices. I think that is terribly important as we do move forward.

Dr. Clancy, I do want to commend you and Secretary McDonald for the responsiveness of the situation. And when this all came to light we immediately went to Secretary McDonald asking for the formal investigation to take place. He did not hesitate. He put you in charge. We had Deputy Secretary Sloan Gibson here a couple weeks ago. We had a chance to brief with him as well. And I commend you for taking these allegations coming out of Tomah seriously and for the attention and the focus that they deserve.

We look forward to working with you and the VA system to fix any problems that might exist.

Thank you, Mr. Chairman.

Dr. CLANCY. Thank you.

Chairman JOHNSON. Congressman Duffy.

Mr. DUFFY. Good afternoon.

Mr. DeSanctis, you were the Director here at Tomah, right?

Dr. DESANCTIS. I am currently at the—

Mr. DUFFY. No. You were?

Dr. DESANCTIS. Yes.

Mr. DUFFY. And for how long in that capacity?

Dr. DESANCTIS. Since February 2012.

Mr. DUFFY. And so the buck stops with you, right?

Dr. DESANCTIS. Yes.

Mr. DUFFY. You got these reports, did you not? You knew what was being said about the Tomah VA. You knew what the employees inside were saying. They told you, right?

Dr. DESANCTIS. The retaliatory accusations did not come to me.

Mr. DUFFY. So you were clueless? You were the Director and you had no idea what was going on inside the Tomah VA by, by the hundreds of employees?

Dr. DESANCTIS. No, that is not correct. Actions that were brought to my attention, I took action to ensure that they were resolved.

Mr. DUFFY. Does it sound like you took action? Because I think Jason's parents would say you did not take action. Or Mr. Baer's family would say you did not take action.

Ms. Clancy, you and I want to touch on this briefly. You and I spoke last week, and, I agree, you cannot diagnose Mr. Baer over the phone. You made a good point. But the fact that he sat in the Tomah VA for an hour and a half showing signs of a stroke where doctors are on staff and nothing happened? They sent him on an hour drive to La Crosse? I mean, this is outrageous stuff.

I mean, the original point you made is fine, but what are we going to do to change the culture inside the VA system, where if we have a veteran who is 74 years old who is showing signs of a stroke, we have to act. It is like out of a movie that you have slow-moving bureaucrats lumping around when a guy is dying. I mean, the Baer family should be absolutely outraged, and they obviously are.

What are we going to do to change culture inside the Tomah VA?

Dr. CLANCY. I think that this was less a culture change issue. First of all, the care was completely and totally unacceptable. I think that needs to be said. And the only thing, we cannot bring him back. I wish we could. But I am moved and inspired by his daughter's being here today and speaking out against this and I hope she does not stop.

Mr. DUFFY. Dr. Clancy, I think what—

Dr. CLANCY. No. What I was—

Mr. DUFFY. If her father did not die in vain.

Dr. CLANCY. No.

Mr. DUFFY. And she knows that changes are going to be made inside.

Dr. CLANCY. Exactly.

Mr. DUFFY. There's not another slow-moving bureaucrat when someone else is in serious critical medical scenarios would actually move and help them?

Dr. CLANCY. We have staffing shortages in that Urgent Care unit, and we are working to rectify those, and we have also worked with nursing staff to identify some very clear deficiencies that were revealed as a result of that care.

Mr. DUFFY. I appreciate that. Did you read the IG report?

Dr. CLANCY. This one?

Mr. DUFFY. Yes.

Dr. CLANCY. Yes.

Mr. DUFFY. Would have you substantiated the claims? I am flipping the role here. Usually the IG is looking at what the VA is doing, but in your role, Dr. Clancy, in the VA, if you had seen that report, would have you substantiated the claims? Would have you made that report public?

Dr. CLANCY. I do not think the results found in that report were definitive. I think this is a problem with our process.

Dr. Houlihan's practices have been reviewed by many external parties. And that is what actually prompted me to remove him from seeing patients and make sure that he could not prescribe further. His privileges were revoked, along with the nurse practitioner in January, was a Review Commission by the network.

Mr. DUFFY. OK. And just by the way, is Dr. Houlihan still employed at the VA?

Dr. CLANCY. He is, yes.

Mr. DUFFY. Is Mr. DeSanctis still employed?

Dr. CLANCY. Yes.

Mr. DUFFY. Ms. Davis, who prescribed the lethal cocktail that killed Jason, is she still employed?

Dr. CLANCY. She is on administrative detail and is under investigation.

Mr. DUFFY. Is she getting a pay check from the American taxpayer?

Dr. CLANCY. Yes.

Mr. DUFFY. She is?

Dr. CLANCY. Yes.

Mr. DUFFY. I think that's what makes people angry here. People are not held accountable and not fired.

Dr. CLANCY. No.

[Applause.]

If I could just say one thing, Congressman. The only thing that would be worse is if we had doubts about a practitioner, rushed through it, and a good attorney made sure that they had to keep a job, and, you know what I'm saying, is that the taxpayers had to pay them for long periods of time.

Mr. DUFFY. I will move on to Mr. Daigh. I thank you for that.

I do not know if we need more evidence, we need e-mails, voice mails, text messages for our burden of proof? As a prosecutor, you could bring in—I was a former prosecutor. You can bring in witnesses that give compelling testimony, and juries can listen to that and they can convict. And it sounds like you had pretty compelling evidence that was presented.

Even Dr. Clancy found that—was it 2.5 percent higher rates of prescription drugs of 400 milligrams? Did I say that a little bit wrong?

Dr. DAIGH. Right.

Mr. DUFFY. And that you have people who are notoriously frightened throughout the Tomah VA and we kind of throw our hands up in the air and go, well, I guess there is nothing going on here.

What I found, when my staff came back and said, listen, you did not want to put, make that report public because you were more concerned about the employees of the Tomah VA than caring for the veterans in the VA system. That is what concerned them and you actually told them that.

In regard to what you are doing now, making all the complaints public, I applaud you for that, but I have to tell you, the perception that we have of the IG is it is arrogant. You are annoyed that you are here. You are annoyed that you have these veterans looking to you to protect them from the VA system and that you are being held to account publically. That is frustrating them. They are frustrated with you.

[Applause.]

I hope you take this back and you listen to the families that testified here and know that you may be the last line of defense for them as they tell their story to you privately, that you go and you work your hearts out for the men and women that raised their hand and served their country and fought for the freedom and the liberty that we enjoy.

You owe that to them and I hope that you leave this hearing and have a new refreshed attitude and devotion and conviction to protect them from inadequate care in the VA system. I yield back.

[Applause.]

Chairman JOHNSON. Congressman Pocan.

Congressman POCAN. Thank you, Mr. Chairman.

I am going to pick up right from there.

Sorry to the IG's office, but you said you have 50 to 60 reports a year. How many of those are administratively closed a year?

Dr. DAIGH. I publish about 50 reports a year. I admin closed over the last 3 years about 20 to 25 reports a year.

Mr. POCAN. Over the last 3 years? So the last 3 years—

Dr. DAIGH. So the average output would be something like 50 reports published to the web, and something like 20 to 25 reports admin closed.

Mr. POCAN. Every year?

Dr. DAIGH. For the last 3 years.

Mr. POCAN. So 50 a year? So 150 versus 25 get administratively closed. How many Freedom of Information Requests do you get from Members of Congress in order to get a report, in that same 3-year period? How many of those did you get?

Dr. DAIGH. I think this is the first time I can recall that.

Mr. POCAN. Do you realize how extraordinary that is? The fact that this report was administratively closed, many of us have a lot of disagreements with the report, and that a Member of Congress had to do a Freedom of Information Request to get the report so we could get even this far? That's part of our frustration that we have.

I served on the Oversight and Government Reform Committee. I dealt with Inspector General's Offices on a lot of different issues and, even now you are going to publish all of them. I would say go one step farther. A little electric file. You could send every re-

port to every Member of Congress and we can decide whether or not it is a report that relates to our district, our committees, or our constituents.

[Applause.]

So a Member of Congress should never ever again have to go to that extraordinary length to get a report from your office. I want to say that.

Let me ask specifically, because I do not want to use up my time.

Jason's case, specifically his family said it, his opiates were not because of an injury. Specifically your report says you did not find any documentation that opiates were used to treat PTSD.

Can you tell me, was Jason's case one of them that you looked at when you did this report?

Dr. DAIGH. No.

Mr. POCAN. It was not, OK. Dr. Clancy, I am going to reiterate what Dr. Walz said and Chairman Miller, please take a closer look at this on behalf of Jason's family, because, clearly, to get 14 or 15 different drugs, it was not even looked at in the report that was not released to us until we had to make a special request to get it. And at least we owe it to the family to figure out, so that for many other veterans, that if they are going to be prescribed something that's not something sufficient, or for the wrong cause, which this seems to be, we need to at least do that.

Dr. CLANCY. I absolutely will and I agree with you.

Mr. POCAN. And let me follow-up too. When I talked to Mr. Honl and Dr. Johnson, before the last panel, specifically when they talked about, for those employees are fairly new that have no protections who want to be whistleblowers, but we do not really protect them, what are you doing specifically, not just here at Tomah, but across the system to figure that out? So that those kind of employees do not feel afraid or have to risk their jobs 2 weeks out from her year, or someone else have to resign because they are not being heard?

Dr. CLANCY. I will be looking into that. I had not recognized that previously as a serious weakness in our system. I will say I am utterly delighted, and I told Noelle Johnson that this morning, that she had found her way back to work in the VHA, so I consider that a real success. I am hoping that we have more of that, that more whistleblowers have a path back, because they are incredibly vital to what we do.

Mr. POCAN. And let me just ask this as, perhaps, a final question. So with what we are seeing here at Tomah and it took to this point the extraordinary lengths to have family members sharing their stories, and how we are finding out potentially about additional deaths that were not at all looked at through an Inspector General report, what are we doing system-wide to make sure that what happened here, not just here, that—we have to fix what is happening in Tomah—this does not happen in other places, because clearly, I wish every pharmacist was like the pharmacist that got fired, because she had the guts to stand up and do the right thing based on that, but what are we doing to make sure that we do not worry about someone who is willing to take that risk, to put their job on the line, to do the right thing?

Dr. CLANCY. So we are doing several things. First is that we had made it very clear and we will continue to make this clear again and again, because you have to make it clear again and again, that retaliation will not be tolerated, No. 1.

No. 2, whistleblowers and people who step forward and say there is something wrong here, who stop the line, right to solve a problem, should be celebrated. We should be giving them awards. The Secretary and I have even discussed a Paul Revere award. I do not know if that is the right name for it. But the bottom line is, we need to celebrate that kind of feedback, because that is how we get better. That is a terrific thing.

In terms of the opiates specifically, we have disseminated a new tool system wide, which makes it much easier for frontline clinicians to have right in front of them how all their patients are doing on all aspects of care, including whether there's been an informed consent, the urine drug testing, what other medications they are on, and are they getting those medications from other parts of our system. So that is a good thing.

And we are mandating that a much more focused effort take place system wide and we will be following that quarterly.

Mr. POCAN. Thank you.

Chairman JOHNSON. Thank you, Congressman Pocan.

I want to thank all of my colleagues here for participating.

I want to thank all the members of the community for coming out and showing your concern and showing your support, being interested.

I certainly want to thank our witnesses for your thoughtful testimony, both in the VA and the Office of Inspector General. I appreciate your comments, Dr. Clancy, now that you have heard the stories and they have affected you. I think they affected all of us.

I want to thank the whistleblowers for your courage for coming forward.

I want to thank future whistleblowers. We need this kind of information if we are going to solve these problems.

I really want to express my sincere gratitude and again condolences to the surviving families.

I remember, I believe when I was talking to you Marv and Heather, and I asked you if you would be willing to come public?

Would you make a public case? Will you tell the story? And I said, if you do that, certainly my commitment would be to hopefully use those stories. If there is any good to come out of this tragedy, it is that your story will be used as a catalyst to enact real reform so again, these tragedies never have to effect another veteran's family.

So, again, I just want to thank everybody for your involvement. Keep telling your stories. Let's keep showing the American people what we need to do.

And you have a commitment from people on this committee to do everything we can to solve these problems.

The hearing record will remain open for 15 days, until April 14 at 5 p.m. for the submission of statements and questions for the record.

This hearing is adjourned.

A P P E N D I X

Opening Statement of Chairman Ron Johnson

"Tomah VAMC: Examining Quality, Access, and a Culture of Overreliance on High-Risk Medications"

March 30, 2015

As prepared for delivery:

Good afternoon. I would like to begin by thanking Chairman Miller of the House Veterans Affairs Committee for his collaboration and leadership in holding today's hearing. I would also like to thank all of our colleagues for their participation.

Today's hearing has been called to examine the disturbing allegations surrounding the Veterans Affairs Medical Center here in Tomah.

The primary goal of this hearing -- and of all our future actions -- is to help prevent tragedies like the ones we will hear about today from happening to other veterans and their families.

I first became aware of problems at the Tomah VA following news reports in January of this year. I immediately assigned committee staff to launch an investigation into what had occurred -- and was occurring -- at Tomah, and the VA's reaction to it. Here is what we have found so far

In April 2003, Dr. David Houlihan was disciplined by the Iowa Board of Medicine for having an inappropriate relationship with a psychiatric patient. According to the executive director of the Board of Medicine, the sanction should have been a serious concern for future employers.

In 2004, Dr. Houlihan was hired as a psychiatrist at the Tomah VA Medical Center.

In August 2005, Dr. Houlihan became chief of staff at the Tomah medical center.

In November 2007, Kraig Ferrington, a veteran who sought treatment at the Tomah facility for medication management died from a lethal mixture of drugs. Autopsy results showed Mr. Ferrington had seven drugs in his system.

In April 2009, it was known and documented by employees at the Tomah VA that many of Dr. Houlihan's patients called him "the Candy Man" and they were concerned that veterans were "prescribed large quantities of narcotics."

In June 2009, Dr. Noelle Johnson was fired from Tomah for refusing to fill prescriptions that she believed to be unsafe. Dr. Johnson had raised concerns to her superiors, had sought guidance from the Iowa medical licensing board, and later spoke with the Drug Enforcement Administration about Dr. Houlihan.

In July 2009, Dr. Chris Kirkpatrick was fired from Tomah. Dr. Kirkpatrick had raised concerns to his union about over-medication at Tomah. Tragically, later in the day of his termination, Dr. Kirkpatrick committed suicide.

In August 2011, the VA Office of Inspector General (OIG) received an anonymous complaint about overprescription and retaliation by Dr. Houlihan at Tomah.

In March 2012, a second anonymous complaint was filed with the IG against Dr. Houlihan. The OIG examined 32 separate allegations during its two and a half year long inspection.

In March 2014, the OIG finished its inspection of Tomah and administratively closed the case without making it public.

On Aug. 30, 2014, Jason Simcakoski died in the Tomah mental health wing as a result of "mixed drug toxicity." Simcakoski was a patient of Dr. Houlihan. His autopsy revealed he had over a dozen different medications in his system.

In September 2014, Ryan Honl began lodging whistleblower complaints about patient safety and quality of care at Tomah.

On Jan. 8, 2015, the Center for Investigative Reporting published an article detailing over prescription and retaliation at Tomah. The article revealed that veterans and employees referred to the Tomah VA Medical Center as "Candy Land."

On Jan. 12, 2015, Candace Delis brought her father, Thomas Baer, to the Tomah VA Urgent Care Center with stroke-like symptoms. Mr. Baer waited over two hours for attention. That day, the facility's only CT scanner was down for "routine preventative maintenance." Mr. Baer passed away two days later.

On Feb. 6, 2015, the OIG finally posted its Tomah health care inspection report on its website.

We continue to gather the facts about what occurred at Tomah. Our investigation is far from over. Revelations of the problems at Tomah have prompted additional whistleblowers to contact our committee with information that indicates systemic problems within the VA health care system.

It is important to acknowledge and thank the members of the media who have uncovered, reported and highlighted the problems within the VA health care system. Without a free press, few if any of these problems would have ever seen the light of day.

Legislatively, this hearing is just the first step. In order to solve a problem, we must fully understand it and be willing to admit we have one. To that end, today we will hear from surviving

family members, former employees, and representatives from the VA, and the VA Office of Inspector General.

Tragically, we will hear the stories of two families, the Simcakoski and the Baer families, who lost loved ones during their treatment at the Tomah facility. They have many questions, and they have a right to have those questions answered.

I want to convey our sincere condolences to the family members and friends of Jason Simcakoski and Thomas Baer. We thank them for being here today so that Wisconsin and the American people can hear their stories first-hand.

The lack of public knowledge and scrutiny of the problems -- not only at Tomah, but at other VA health care facilities -- indicates that transparency and accountability both within the VA and the VA Office of Inspector General must be improved.

As the last two months have shown, the crucial first step in improving service and the quality of care in the VA health care system is a process for transparent disclosure.

In spite of the revelations regarding the Tomah facility, I still believe that the vast majority of men and women working in Wisconsin's VA facilities are dedicated to providing quality care to the finest among us.

Nevertheless, the VA and the VA OIG must take necessary steps to ensure that substandard clinical practices and the retaliatory tactics used at Tomah never occur or go unreported again.

We owe our veterans the best possible treatment and care. I hope that, with proper oversight, increased transparency and swift accountability within the VA, that goal will be achieved.

Statement of Ranking Member Tom Carper
“Tomah VAMC: Examining Quality, Access, and a Culture of Overreliance on High-Risk
Medications”
March 30, 2015

Ranking Member Tom Carper (D-Del) submitted the following statement for the Record:

“First, I want to thank my colleagues Chairman Ron Johnson and Senator Tammy Baldwin for working together to address this serious issue and for holding this important hearing today.

“As a veteran, I understand the sacrifices that the men and women of the Armed Forces and their families have made to defend our country and the freedoms we cherish. We have a responsibility to ensure that our returning heroes have the support and the resources they need when they come home, and to make sure they are taken care of long after. That includes ensuring that veterans have access to top quality health care.

“I was deeply troubled to learn about allegations of maltreatment of veterans and a management ‘culture of fear’ at the U.S. Department of Veterans Affairs Medical Center (VAMC) in Tomah, Wisconsin. A January 2015 report from the *Center for Investigative Reporting* described a disturbing and heartbreaking situation that put veterans in harm’s way at a place that should be helping them. The report highlighted growth in the number of opiate prescriptions at the Tomah VA, which more than quintupled from 2004 to 2012 even as the number of veterans seeking care at the hospital declined. The report also noted that some veterans started calling the center “Candy Land,” and a high ranking official at the facility the “Candy Man” as a result of the number of controlled substance prescriptions dispensed under his watch. Patients would “show up to appointments stoned on painkillers and muscle relaxants, doze off and drool during therapy sessions, and burn themselves with cigarettes,” according to the report. Tragically, Jason Simekakoski, a 35-year-old Marine Corps veteran, died in August as a result of an overdose in the facility’s psychiatric ward.

“Our veterans deserve better than this. Practices such as those found at Tomah and reports of other misconduct at VAMCs across the country are simply unacceptable. Congress, the Administration, and the VA leadership need to work together to fully investigate this and any instance of misconduct and do whatever it takes to prevent similar incidents from happening again.

“Today in Tomah, we have an important opportunity to learn the facts from the families and individuals affected directly by events at the Tomah VAMC. I thank the witnesses for being with us today and I appreciate their courage to stand up and shine a light on this deeply troubling situation. Their stories should remind us all of the solemn responsibility we share to ‘to care for him who shall have borne the battle.’ We will also hear from the VA and its Assistant Inspector General for Healthcare Inspections on what went wrong and what corrective steps they’re taking to address this problem immediately.

“On March 10 of this year, the VA released its summary of phase one of its clinical review of prescribing practices at the Tomah VAMC. The VA found that unsafe clinical practices in areas such as pain management and psychiatric care revealed that patient harm could be at least partially attributable to prescribing practices at the facility. Further, the VA also found that an apparent ‘culture of fear’ at the

facility compromised patient care and hurt staff satisfaction and morale. Additional reviews at the facility are ongoing.

“Finally, while the work of the VA Inspector General’s office has been helpful in uncovering a number of issues with the Tomah facility, I am concerned about the lack of access to timely information from that office on conditions at the Tomah VAMC. Earlier this month Chairman Johnson, Senator Baldwin, and I joined with our colleagues on the Homeland Security and Governmental Affairs Committee to approve legislation that makes key reforms to enhance oversight and greater transparency in the work that is conducted by our Inspectors General. Under this legislation, the work of the Inspectors General would have to be sent to the agencies’ leadership and appropriate Congressional committees so that action can be taken when necessary to fix problems that are uncovered. Inspectors General would also be required to post reports online no more than three days after agency leadership receive them.

“As I’ve said before, fixing the problems at the VA isn’t a partisan issue. It’s a shared responsibility among Congress, the Administration, and the VA’s leadership. We must continue to work together to improve veterans’ access to health care and to restore both veterans’ and taxpayers’ trust in the VA.”

Opening Statement of Senator Tammy Baldwin
"Tomah VAMC: Examining Quality, Access, and a Culture of Overreliance on High-Risk Medications"
March 30, 2015

As prepared for delivery:

Chairman Johnson, Chairman Miller, thank you for organizing this joint hearing today. To my Congressional colleagues from the Wisconsin House delegation, thank you for joining us today. I also want to welcome you, Congressman Walz and Congressman Abraham to Wisconsin.

I think the fact that there are members from both parties, from both the Senate and the House, sends an important message to this community that we share a bipartisan commitment to get to the bottom of the problems at the Tomah VA, and to work together across party lines to make sure they never happen again.

I hope I speak for all of us when I say that there is no room for politics when it comes to ensuring that our nation's veterans receive the timely, safe, and highest-quality care that they have earned.

I would also like to take this opportunity to say thank you to the panelists for joining us here today. In particular I would like to say that I have a tremendous amount of respect for the courage of Candace, Ryan, Noelle, Marv and Heather, to tell your stories today.

Stories of a sacred trust we must have with our veterans and their families. Stories of how that trust has been broken. Tragic stories of loss.

Today, we are here to fix what has been broken and work together to restore that trust. I want you to know that the stories you give voice to today will help us do that for others veterans.

The problems at the Tomah VA are both sobering and have had tragic consequences. Going back to 2006, veterans who were patients at the Tomah VA have tragically lost their lives.

Veterans who served our country -Angela Colby, Michael Bobak, Jacob Ward, Derik McGovern, Kraig Ferrington, and Jason Simcakoski were under the care of the former Tomah Chief of Staff and treated with prescription drugs, and all of them subsequently died of a drug overdose.

In fact, according to his sister Kari, who is here with us today, Mr. Ferrington, an Army veteran from De Pere, Wisconsin, died from a lethal mixture of prescription drugs in 2007 while under the care of the former Chief of Staff. The same cause of death that would tragically take the life of Jason Simcakoski some seven years later.

These are six examples of a larger problem that is in desperate need of solutions today. As we all know, after two, decade long wars, a large number of our service members are coming home with the damage of combat.

Our veterans and their families are facing a difficult challenge of physical injuries and PTSD and other mental illnesses. We must confront these problems more aggressively and more effectively and help them meet that challenge.

I believe the VA's overreliance on opioids has resulted in getting our veterans hooked instead of getting them help.

Over-prescription of opioids at the VA is clearly a root problem, but we must not lose sight of the fact that it is growing into a weed of addiction whose impact is being felt beyond the VA walls. The devastation of addiction, on families and our communities, that is being grown at the VA is stunning.

Reports indicate that, six years ago, a Marine Corps veteran was stoned on painkillers and tranquilizers from the Tomah VA while driving and killed a 6-week-old child, Ada Mae Miller.

As the Center for Investigative Reporting wrote about the Tomah VA medical center,

"Ada Mae's death is one of dozens of tragedies that begin to hint at how the flood of narcotics from the VA scarred this region."

The fact is the problem of overprescribing at the VA and the collateral damage of addiction is not unique to Wisconsin. We are not alone.

The ripples are indeed being felt across America, in communities we work for everyday in Washington.

The families we have a responsibility to represent are struggling with the loss of a son or daughter, a father or mother, a sister or brother to addiction whose root is planted within the VA system. It is our job to make sure they do not feel alone and I believe we have a shared responsibility to do everything we can to pull this root out.

I thank you for providing me an opportunity to join you today. I look forward to continuing my work with this community and my colleagues in Congress to address these problems and put solutions in place to prevent these problems and tragedies from ever happening again.

**Opening Statement of the Honorable Jeff Miller
Chairman, Committee on Veterans' Affairs
U.S. House of Representatives**

"Tomah VAMC: Examining Quality, Access, and a Culture of Over-Reliance on High-Risk Medications"

March 30, 2015

Thank you, Chairman Johnson.

I am Jeff Miller, the Chairman of the Committee on Veterans' Affairs for the United States House of Representatives and Congressman for the First District of Florida.

While I am here under circumstances that are disturbing to say the least, I am grateful to be in Tomah with you this afternoon.

Ladies and gentlemen, those of us up on this dais today are from different political parties, different houses of Congress, and different parts of this state and this country.

Yet, we are all united here in Tomah today because partisanship, stovepipes, and gridlock have no place where our nation's veterans are concerned.

Let me begin my statement by expressing my condolences to the Simcakoski family and the Baer family and to all of you here today who have lost loved ones or been left to carry the scars of poor treatment by the Tomah Department of Veterans Affairs Medical Center (VAMC).

However, let me assure you that your pain serves a purpose and your calls for help and for change have been heard.

Concerned employees and worried veterans have tried to blow the whistle here for years, only to be met with seeming silence by the Inspector General (IG) and VA.

When the problems finally got the attention they deserved, the IG and VA learned what so many here had known all along – that some providers were recklessly prescribing opioids and other high-risk medications that, in some cases, were actively harming veteran patients and that facility and VISN leaders allowed a culture of fear, reprisal, and retribution to fester until it infected staff morale and impacted patient care.

Unfortunately, many of the issues surrounding medication management and a lack of accountability that we will discuss today are not outliers but symptoms of system-wide issues that our veterans and their families face in communities like this one every day.

I recognize that pain – particularly the chronic pain and accompanying comorbid conditions that many of our veterans experience – is complex and difficult to treat.

I also recognize that VA is joined by the medical community at-large in grappling with how to best treat chronic pain and ensure safe, effective use of opioids and other high-risk medications.

However, I have heard VA officials use those two facts as de facto excuses for irresponsible medication management practices and systemic lack of accountability for far too long, while our veterans and their families continue to suffer the devastating consequences of VA's inaction.

It's time for a new message.

We cannot rewind the clock and bring to light - before yet another year of inaction passed - the results of the IG's initial three year investigation that found serious concerns.

We can never bring back Jason Simeakoski or Thomas Baer.

But we can use the lessons we learned here in Tomah to improve the care our veterans receive and ensure that no other veterans, families, or VA employees suffer like some here have.

I thank you all once again for being here this morning and I look forward to hearing your testimony.

With that, I now yield back to Chairman Johnson to recognize our Acting Ranking Members and introduce our witnesses.

Statement of Noelle Johnson PharmD, BCACP, CGP**"Tomah VAMC: Examining Quality, Access, and a Culture of Overreliance on High-Risk Medications"****March 30, 2015**

I worked at the Tomah VA as a Clinical Pharmacy Specialist from July 2008 to June 2009. I was fired after refusing to fill several narcotic prescriptions prescribed by Dr. Houlihan that I believed to be unsafe. I filed a whistle blower complaint with the Office of Special Counsel, which was denied, and later the Merit System Protection Board. The VA requested federal mediation. I settled out of court in 2010. I was fully reinstated, my service computation date was moved back six months, and I received a monetary settlement.

The whole basis for my whistle blower complaint was that I refused to fill several of Dr. Houlihan's narcotic prescriptions that I did not believe to be safe. I do believe I was terminated for blowing the whistle as I was contacted by DEA and agreed to interview with them. I met with DEA agent Thomas Hill June 2009. I was fired a few weeks later. In my OSC complaint Dr. Houlihan and several others referenced that I turned him into the Inspector General, in which I did not. I believe that played into my termination, however Dr. Houlihan's retaliatory behavior is not the basis of your investigation. I truly believe that Dr. Houlihan is a very dangerous man. What makes him so dangerous is his lack of respect for the medication. Whatever his motives are for prescribing the current doses of medication is almost irrelevant. To this day I still question his motives, whether it be power, monetary gain, negligence, ignorance, or maybe all of the above. The truth of the matter, the quantities of narcotic medications coming out of the Tomah VA facility is irrefutably unsafe. This has been demonstrated by several cases of overdose and deaths. Over 2,000 911 calls from the Tomah VA Medical Center with 24 unexpected deaths over the last five years. There were three unexplained deaths in the Tomah VA parking lot in a matter of four months all Veterans receiving care from Dr. Houlihan just in the year time frame I spent at the Tomah VAMC.

The three questions that need to be asked are simple. First, what makes the Tomah VA patient population so 'complex' as the Tomah Director Mario DeSanctis put in his television debut, that they require the number of narcotics that are being dispensed? I am currently working as a double board certified Clinical Pharmacy Specialist in the Pain Management Clinic at the Des Moines VA. I am the facility lead for the National Opioid Safety Initiative. I can assure you the patients at the Tomah VA are no more complex than the patients we see daily at the Des Moines VA. We have an acute psych ward, a domiciliary with a substance abuse program, post traumatic stress recovery program, as well as several cognitive behavioral therapy recovery programs. We have a long term care facility where Veterans were rejected or denied care elsewhere just as those at the Tomah VA, and we are not prescribing even one fourth of the current narcotics they are. Specifically as the VHA directive is to limit morphine equivalents (MEQ) to less than 200mg/day and limit the combination of opioids and benzodiazepines due to increased rate of mortality. I do not believe Tomah would be in compliance with this National Directive as pointed out in Under Secretary Clancy's investigative teams' clinical review. Out of 18 patient reviews the team found "unsafe clinical practices at the Tomah VAMC in areas of pain

management and psychiatric care. Six out of 18 cases revealed patient harm attributable to prescribing practices. Nine of 18 lacked evidence of changing the treatment in the face of aberrant behaviors and twelve of 18 demonstrated extensive use of opioids and benzodiazepines. Tomah Veterans were 2.5 times more likely than the national average to be prescribed opioids greater than 400mg of MEQ. The Tomah VA was found to prescribe benzodiazepines in combination with opioids at almost double the national average." Dr. Houlihan used to reference his own case studies as documentation and justification to why he used benzodiazepines to treat Post Traumatic Stress Disorder which is not currently recommended or standard of care. Use of benzodiazepines in PTSD treatment has been shown to worsen the condition and cause harm. Not only were these Veterans treated inappropriately with benzodiazepines often in doses well above the maximum recommended daily doses, but in combination with opioids which is also not recommended due to the increased mortality rate in combination. I am struggling to understand the variance between what the Under Secretary's Team found and the report that was administratively closed by the Inspector General. It was noted in the Inspector General's report that they "did not substantiate the allegation that opioids were prescribed inappropriately to specific individuals or in inappropriate doses." They did however find that "opioids prescribed by Dr. Houlihan and Deb Frasher in aggregate and to individual patients were at considerable variance compared with most opioid prescribers in VISN 12." Unfortunately for all Veterans receiving care at the Tomah VA, the "considerable variance" wasn't enough to warrant serious consideration by the Inspector General as the investigation was administratively closed leading to continued harm to our nations Veterans.

Secondly, exactly what type of 'pain' is the Tomah VA treating that they are prescribing these dangerous quantities and dosages of opioids published in the most recent investigations. Studies show there is no proven long term benefit of opioid medications let alone at the significant doses being prescribed. As a pain specialist I can assure you if someone is actually taking that amount of opioids they would have serious side effects including respiratory depression and constipation. Many would be experiencing hyperanalgesia due to overloading the Mu receptor which leads me to believe that Veterans are not taking all of the prescribed medications and are at high risk for diversion. This was a "substantiated" finding by the Inspector General. They substantiated the allegation that negative urine drug screens (UDS) were not acted on and that controlled substances were still prescribed in the face of negative urine drug screen. They found that for some patients, when a UDS was performed and showed absence of prescribed medication, documentation in progress notes did not always acknowledge this or indicate what, if any, clinical intervention or change in treatment was initiated with the patient. For example they found in a selected case a Veteran had multiple negative UDS that did not show the presence of prescribed medications that was not acted on. 52 out of 56 patients had a UDS performed at least one time in three years. It is standard of care and part of the Opioid Safety Initiative to obtain a UDS at least annually if not more frequently in the face of aberrant drug related behavior. The remaining four Veterans had no UDS performed during the time frame spanning more than three years, although all were treated chronically with opioids during that time period. Of the 52 Veterans, there were five patients who were being prescribed opioids at the time of the negative urine drug screen. This is indicative of aberrant drug related behavior, misuse, abuse, or diversion. These were the findings for a urine drug screen obtained once over a three year time period. What would the numbers have been if

the providers actually followed the standard of care and obtained them at least annually? Yet again the investigation was administratively closed.

The 3rd issue that needs to be considered is why is a psychiatrist prescribing opioid pain medications at the Tomah VA facility? The psychiatrist at the Des Moines VA would not dream of prescribing these medications as it is beyond their scope of practice. Even if Dr. Houlihan was prescribing these medications because he was the Chief of Staff, he has no specialty training or credentialing in pain management. That would be equivalent to Dr. Houlihan prescribing Oncology medications to a cancer patient. Either way it is beyond the scope of standard practice.

I am tremendously disappointed in our federal system and the current authoritative figures that are to be our governing agencies set in place to protect our Veterans and employees. I have interviewed with the DEA three times and had a thorough interview with the Inspector General. I am extremely disappointed with Dr. Daigh, Dr. Mallingen, Mr. Griffen and the whole Inspector General investigative team. Of the 32 allegations that were investigated, many were "unsubstantiated." What is disturbing is that I lived that torture and saw the unsafe practice daily. I can attest to several of the 32 allegations and believe the majority should have been "substantiated." The Inspector General's investigation did "substantiate" several allegations, however they still "did not find any conclusive evidence affirming criminal activity, gross clinical incompetence, or negligence, or administrative practices that were illegal or violated personnel policies." This is unfathomable for the reasons outlined above and following:

I can advise that I alerted and/or questioned Dr. Houlihan on a few different narcotic scripts which is outlined in the Office of Special Counsel complaint. All are very concerning for safety reasons, however the one that concerns me the most is the Oxycontin that the local medical doctor was tapering and discontinuing due to testing appropriately positive for methadone which he was not prescribed by either the local provider or Dr. Houlihan. This Veteran was double dipping Oxycontin from local medical doctor and the VA with refill dates only a week or two apart for 30 day supplies. In addition to the inappropriate urine drug screen obtained by the local medical doctor and abuse of opioids, the patient left his cell phone in pharmacy. When the pharmacist, Dave Dettle picked up the phone the person on the other end was asking to buy medication from this Veteran. All this was documented in the chart and despite the information provided Dr. Houlihan decided to re-write the prescription for Oxycontin three times daily. This was an increase in the frequency prescribed. I do not understand why a provider would do that. This supports the "substantiated" findings of Dr. Clancy's team. As expressed above Veterans were still prescribed narcotics in the face of aberrant drug related behavior. From a clinical stand point I am unclear why Dr. Houlihan prescribes the medications in the manner of which he does. My clinical opinion is irrelevant. What matters is the standard of care set in place for providing safe and effective care to our Veterans. For example the 1,080 immediate release morphine tablets that were dispensed. When confronted, Dr. Houlihan refused to change this patient to long acting medication which would have been standard of care or add something non-narcotic to treat his neuropathic pain. In addition he continued to prescribe 36 tablets a day to a known substance abuser who was overusing his morphine while in the hospital. I understand that you would need to taper if you were going to do that, however that was never the plan, nor was addressing the patients 'pain' with the standard of care. Another example is of a prescription for 1,447mg of MEQ per day that Dr. Houlihan and Dr. Hyde worked on

together. That patient dangerously increased his own medication which in my pain clinic would be grounds for discontinuation due to the inability to safely take opioid medications. They gave this patient a 30 day supply of medication when he was supposed to be admitted to the inpatient facility the following week. Based on the calculation of his current supply even with the increased dose he would have had enough medication to get through until admission so why was he dispensed 30 day supply of a high risk medication that he was currently abusing. The Veteran just got done dangerously increasing his own dose, and Dr. Houlihan gave him more to take on his own despite the dose being at considerable variance compared to the recommended VHA Opioid Safety Initiative dose limit of 200mg of MEQ per day. That is how you have accidental or non-accidental overdoses in your parking lot. I retrospectively reviewed the Veterans profile the following week and he was not admitted according to the plan of care. When I went to the MSPB mediation and the documents were brought to discovery there was a progress note from Dr. Hyde's husband (Rod Hyde - PA in Tomah - not involved with this particular patients care) discussing an admission for this particular Veteran. It is my belief the records were altered. This concern has been brought forth by several others, some that continue to work at the Tomah VA. My experience with Dr. Hyde was somewhat limited, as I was only at the Tomah VA for one year, however she had no prior pain management experience yet she seemed to do exactly what Dr. Houlihan asked despite evidence of patient harm. I was kicked off the new pain committee and opioid work group that I had been appointed to by the Quality and Safety director by Dr. Houlihan who promptly replaced me with Dr. Hyde, which I do not believe to be a coincidence. Dr. Hyde is now being investigated by the Wisconsin Department of Safety and Professional Services. I had very little interaction with Deb Frasher. The only thing I heard her say is that she believed that every patient needed a 'cocktail' which consisted of an opioid, benzodiazepine, stimulant, and sleeping medication. The one question I would address about Deb Frasher is that if she is seeing patients for mental health then why is she prescribing 5.3 million mg of MEQ? What is she treating? When did it become acceptable or the standard of care to treat 'psychological pain' with opioids. This finding was "unsubstantiated" by the Inspector General, however I saw this indication for opioids in several charts.

I shared my concerns of Dr. Houlihan's over prescribing of narcotic medications, and I say narcotics, not just opioids as he over prescribes benzodiazepines as well as stimulants and other antipsychotic medications inappropriately. I saw several benzodiazepine scripts prescribed above the max doses. I also saw several stimulant prescriptions such as Methylphenidate and Dextroamphetamine prescribed at double the maximum recommended dosage set forth by the manufacturer and Federal Drug Administration. The Veterans in the Tomah VA appeared significantly overmedicated. Several Veterans appeared to be suffering with extreme extrapyramidal side effects due to the unsafe combination of medications being prescribed. After reviewing the interview with MSNBC and Fox News the list of medications the Tomah VA prescribed Jason Simcakoski did not follow evidence based guidelines or the standard of care. For example a weak opioid was prescribed with suboxone which should never be done. Diazepam was prescribed at 60mg per day with the maximum dose allowed being 40mg per day. Jason was being prescribed duplicate therapy with the benzodiazepine diazepam and temazepam which is dangerous and not the standard of care. He was also on several other interacting medications including several medications that affect serotonin which put him at high risk for serotonin syndrome which can be lethal and unfortunately was. As a pharmacist I would not have dispensed these

medications in combination or the dosages and frequencies in which they were prescribed. One of my concerns regarding the care provided by the staff at the Tomah VA in regards to Jason's care is that the mixed drug toxicology that eventually led to his death likely did not occur overnight. I would have suspected the Veteran would have displayed signs and symptoms of over sedation, respiratory depression, CNS depression, and cognitive impairment. If this was the case, was there evidence of gross clinical incompetence and negligence? This should have been identified by the medical team and acted on. This Veterans death was a preventable tragedy. Had the Inspector General done their due diligence and reported their findings despite the administrative closing of the investigation, the outcome could have been a very different one.

Majority of my clinical colleagues with the exception of Dr. Hyde agreed with my safety concerns. I alerted my Chief of Pharmacy Dr. Erin Narus who ordered me to illegally partial a Methylphenidate script prescribed by Dr. Houlihan as neither of us concurred with the current dosing regimen as it was prescribed above the maximum recommended dosage and frequency. Dr. Narus asked me to illegally change the script and the directions without the provider's approval and only provide a seven day supply until further clarification from Dr. Houlihan. I told my Service Line Chief Jeff Evanson and his response to me being asked to do something illegal was "why are you trying to cause trouble? Why are you throwing Erin under the bus, if Dr. Houlihan wants you to fill that medication than you have no right to say no." I reported my concerns to the President of the Union, the VISN pharmacy leaders, the DEA, and later the Inspector General, as well as the WI board of pharmacy. The WI Board of Pharmacy could not be bothered to return my phone call after several attempts. I alerted my licensing agency, the Iowa Board of Pharmacy, who advised me not to fill the prescriptions and bring the matter to local authorities as I was 50% liable for those medications being dispensed. I was not going to be responsible for another death in the parking lot or contribute to suspected medication diversion. The unfortunate part of all of this, is that despite all who knew, nothing has been done. The true tragedy is that more Veterans had to die because the OSC determined "my clinical opinion" was different than Dr. Houlihan.

The depths of this tragedy are far reaching. I recently received a pain management consult for a Veteran at the Des Moines VA. This Veteran was a prior Tomah patient who was treated by Dr. Houlihan and Deb Frasher. This particular Veteran had a long standing history of substance abuse with alcohol and narcotics. The patient was previously taken off of opioids due to aberrant drug behavior and overdose. The Veteran was placed on suboxone by Dr. Houlihan, which the patient reports he never took to only be placed back on large doses of opioids and benzodiazepines by Dr. Houlihan. The patient has since had two more admissions for overdoses within the past 2 months. He is currently being taken off all his opioids and benzodiazepines. If this Veteran's family had not sought care elsewhere and the patient continued to receive care by Dr. Houlihan and Deb Frasher would his second and third overdoses been enough for them to finally take this veteran off of such a dangerous medications? I am unclear how the Inspector General could not "substantiate" these findings or "find no conclusive evidence of gross clinical incompetence or negligence." Veterans have lost their lives because of this prime example of gross clinical incompetence and negligence.

I have personally dealt with the repercussions of administrative practices that were illegal and that violated all sorts of personnel policies. I was asked to do something illegal, refused, blew the whistle on this gross clinical incompetence and negligence outlined above, and was fired for standing up and doing what was safe and right for the Veteran. The Inspector General did find that, "pharmacy staff uniformly indicated that they were reluctant to question any prescription ordered by Dr. Houlihan or any aberrant behavior by his patients because they feared reprisal." This was eventually "unsubstantiated" by the Inspector General despite findings of consistent, documented early refills, inappropriate urine drug screens, unsafe narcotic dosages, quantities, and dosage frequencies, as well as other drug related aberrant behavior. If all these findings were "unsubstantiated" why have so many clinicians left the Tomah VA? The one pharmacist who was brave enough to stand up and question those prescriptions for our Veterans safety was fired. The precedence of "what not to do if you value your job" was set.

My second Chief of Pharmacy Tom Jaeger reported he was coerced into writing his falsified personal statement that helped lead to my termination. He agreed to take it back, he then resigned two days after I was terminated. He then wrote another report of contact which stated he would not recant his statement. My clinical colleague Heather Astmus and Rebecca Bell were pulled into Dr. Houlihan's office where he essentially told them if they value their job they would not question him like I did. Shortly before my termination Dr. Zakia Siddiqi resigned in lieu of termination after refusing to write for an opioid that a veteran did not test positive for in his urine drug screen, indicating aberrant drug behavior. In addition I was told in a pain committee meeting that we were not to be drug testing our patients as when they did not test positive for the substance prescribed and we continued to prescribe the medication we were liable. I do believe that is the point of urine drug testing to substantiate use and misuse of high risk medications for the safety of the Veterans and public. This was a "substantiated" finding by the Inspector General. Dr. Houlihan proceeded to tell Union Steward Dianne Streeter that there would never be a pain clinic at the Tomah VA and if pharmacy took over pain management then patients would start dying, after which they would bring their guns to pharmacy and start shooting. The "Candy Man" statement the CIR references is legitimate. I heard more than one Veteran reference Dr. Houlihan as this. I heard a particular patient in the hall way say "my primary care doctor took me off of my narcotics, you need to see Dr. Houlihan because he will put you back on them just like he did me."

I continue to have grave concerns about the clinical abilities of several providers at the Tomah VA, including concerns ignored or "unsubstantiated" by the Inspector General. What will it take for those in a position of authority to take significant action? 911 was called more than 2,000 times over the last five years reporting 24 unexpected deaths. How many Veterans lives need to be lost? We are to be taking care of these Soldiers' returning from war, not creating a war they will not survive. What happened to the doctors oath of "First Do No Harm?" It is all of our responsibility to stand up for those Veterans safety and not contribute to the tragedy that has cost so many lives. The leadership at all levels; Tomah, VISN, VACO, and Inspector General need to be held accountable or true change will never prosper and Veterans will continue to suffer the ultimate sacrifice. Those Veterans deserve the highest

quality of care afforded. I urge and encourage you to deeply consider and investigate all allegations against the Tomah VA and their providers.

UNITED STATES OF AMERICA
MERIT SYSTEMS PROTECTION BOARD
CENTRAL REGIONAL OFFICE

NOELLE A. JOHNSON,)	DOCKET NUMBER
)	CH-1221-10-0336-W-1
Appellant,)	
)	
v.)	
)	
DEPARTMENT OF VETERANS AFFAIRS,)	DATE: September 16, 2010
)	
Agency.)	
)	

SETTLEMENT AND COMPROMISE AGREEMENT

It is hereby agreed by and between the U.S. Department of Veterans Affairs ("Agency") and Noelle Johnson ("Appellant") as follows:

1. After negotiation, the parties do hereby agree to settle and compromise MSPB Appeal No. CH-1221-10-0336-W-1, under the terms and conditions set forth herein.
2. In exchange for Appellant's agreement to have the above-referenced MSPB Appeal dismissed, and waive any and all actions, claims, complaints, grievances, appeals and proceedings of whatever nature against the Agency, its officers and employees, in their personal as well as official capacities, which are now or hereafter may be asserted by her or on her behalf regarding her termination in June of 2009, and as well as regarding any other facts in existence as of the date of Appellant's execution of this settlement agreement ("Effective Date"), with the exception of any claims that may arise by reason of breach of any term of this settlement agreement, the Agency agrees to:

- a. Accept Appellant's resignation, effective December 31, 2009. This resignation will be evidenced by a Government Standard Form 50 in Appellant's Official Personnel File. Appellant will be coded as in Leave Without Pay (LWOP) status from July 1, 2009 to December 31, 2009 and will not be paid for the period July 1, 2009 to December 31, 2009;
- b. Remove and destroy any and all documentation from Appellant's Official Personnel File concerning her removal;
- c. Pay Appellant \$61,000 ("Payment") via electronic deposit to the client trust fund of Stix Law Offices, 700 Rayovac Drive, Suite 117, Madison, WI 53711, Tax I.D. No. 36-3489826;
- d. The \$61,000 is allocated as follows: \$15,000 for attorney fees and \$46,000 for promised educational expenses; and
- e. To allow Appellant thirty days from the Effective Date of this Settlement Agreement to appeal the Agency debt collection action concerning her Tomah VAMC sign-on bonus and relocation bonus and freeze/ hold in abeyance collection activity involving these bonuses until her appeals are complete.
- f. That David Houlihan, M.D., will not make any written or oral communication that would disparage Appellant concerning her performance as a clinician at the Tomah VA Medical Center. The parties agree that this clause does not apply to responses by Dr. Houlihan to inquiries from State or federal regulatory agencies.

3. In consideration for the performance of the Agency as required by paragraph 2 of this Settlement Agreement, Appellant agrees as follows:

- a. Appellant hereby forever waives and releases all claims that she has alleged or could have alleged against Secretary Eric K. Shinseki and his successors, and any of his employees, including but not limited to past and present officials or employees of the U.S. Department of Veterans Affairs, in their official or individual capacities, as set forth in MSPB Appeal No. CH-1221-10-0336-W-1, and agrees to the dismissal of that MSPB Appeal with prejudice. Appellant further waives her right to file or pursue any complaint, claim, lawsuit, grievance, or appeal at any time in the future against the Agency, or any officials, employees, or former officials or employees of the U.S. Department

of Veterans Affairs, or its successors or assigns, its officials, employees, or former officials or employees, in their official or individual capacities, in any state or Federal court, or before any administrative body, tribunal, board, or commission, based upon any issues or claims arising out of her employment with the Tomah VA Medical Center occurring prior to and including the Effective Date of this Settlement Agreement. This waiver includes but is not limited to any matter described in, referred to, or arising out of the matters that were the subject of the Appellant's MSPB Appeal, or the negotiation or execution of this Settlement Agreement;

b. Appellant hereby waives any and all claims for attorneys' fees or costs, whenever incurred, as well as any and all attorneys' fees or costs incurred in relation to this Settlement Agreement, other than those specifically enumerated in paragraph 2. Appellant explicitly understands that the Payment is inclusive of all attorneys' fees and costs for legal representation in the actions;

c. Appellant agrees, subsequent to the Effective Date of this Agreement, not to seek, apply for, or accept a position (to include independent contractor positions) with the Tomah VA Medical Center or any of the Tomah VA Medical Center's affiliated clinics in Wisconsin for a period of five years. If Appellant applies for a position in violation of this provision of the Settlement Agreement, the Agency may reject her application regardless of whether she is qualified for the position. If Appellant applies for and is hired for a position in violation of this Settlement Agreement, the Agency may remove her, immediately upon discovery of the breach, to achieve compliance with the terms of this Agreement. Appellant shall have no administrative recourse or

cause of action in any forum if the Agency takes any action described in this clause to cure Appellant's breach of this clause.

4. Appellant agrees that she will not make any written or oral communication that would disparage David Houlihan, M.D., concerning his performance as a clinician or manager at the Tomah VA Medical Center. The parties agree that this clause does not apply to responses by Appellant to inquiries from State or federal regulatory agencies.

5. The terms and conditions set forth in Paragraphs 2 and 3 are in full settlement of any and all claims, demands, rights, and causes of action of any kind and nature, resulting from the same nucleus of operative facts giving rise to the claims in the above-captioned appeal.

6. This settlement agreement shall not constitute an admission of liability or fault on the part of the Agency, its agents, servants, or employees, and is entered into by both parties for the purpose of compromising a disputed claim and avoiding the expenses and risks of litigation.

7. It is also agreed, by and among the parties, that the settlement amount and terms and conditions described in Paragraphs 2 and 3 represent the entire agreement and that the respective parties will each bear their own attorney fees, tax obligations, costs, and expenses, aside from those fees, costs and expenses specifically provided for in this Agreement.

8. This Settlement Agreement shall not serve as a precedent for resolving any other complaints, grievances, appeals or actions, which have been or may be filed.

9. In consideration of the terms set forth in Paragraphs 2 and 3, Appellant agrees to execute and file with the Merit Systems Protection Board such documents as shall be necessary to cause the above-captioned appeal to

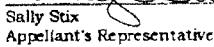
be dismissed. This Agreement will be made part of the overall record and the Merit Systems Protection Board will retain jurisdiction to ensure compliance with the agreement.

THE PARTIES TO THIS AGREEMENT HEREBY SIGNIFY THEIR UNCONDITIONAL ACCEPTANCE OF EACH AND EVERY TERM OF THIS AGREEMENT BY SIGNING ON THE FOLLOWING SIGNATURE LINES.

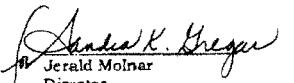
Dated: 9/20/10


Noelle Johnson
Appellant

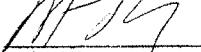
As to form only:


Sally Stix
Appellant's Representative

Dated: 9/27/10


Jerald Molnar
Director
Tomah VA Medical Center
Department of Veterans Affairs

As to form only:


Michael Newman
Assistant Regional Counsel
Milwaukee Office of Regional Counsel
Department of Veterans Affairs

**NOTICE OF WITNESS OBLIGATIONS, PROTECTIONS, AND PRIVACY ACT
MATTERS**

1. VA Regulation 38 CFR 0.735-12(b) states, “**Employees will furnish information and testify freely and honestly** in cases respecting employment and disciplinary matters. Refusal to testify, concealment of material facts, or willfully inaccurate testimony in connection with an investigation or hearing may be grounds for disciplinary action. An employee, however, will not be required to give testimony against himself or herself in any matter in which there is indication that he or she may be or is involved in a violation of law wherein there is a possibility of self-incrimination” (emphasis added). In addition, VA Directive 0700 requires all employees to cooperate with administrative investigations to the extent permitted by governing laws, regulations, policies, and collective bargaining agreements.
2. For individuals who are not VA employees, participation and testimony in this investigation is generally voluntary unless it is obtained by subpoena.
3. You may refuse to answer a question if you believe the answer could be used to convict you of a crime. If you refuse to answer on this basis, you must inform the investigator or board that you are asserting this right. No adverse action may be taken against you for such a refusal unless you have been assured that your answer will not be used against you in a criminal prosecution. You do not have the right to refuse to answer a question based on a belief that your response may incriminate a person other than yourself, or that it may result in adverse administrative action against you.
4. VA Directive 0700 requires you to refrain from disclosing any information developed in the course of the investigation, including the substance of your testimony, with others, if so directed by the Convening Authority or by a member of the Administrative Investigation Board. This is to protect the integrity and fairness of the investigative process. You may, however, discuss such matters with Federal investigators, with the Office of the Inspector General, the Office of Special Counsel, or with your designated personal advisor or representative (if any). In addition, you will not be reprimanded against for any disclosure protected by the Whistleblower Protection Act or other law.
5. You will be protected from reprisal for providing truthful testimony or otherwise cooperating lawfully with this investigation. If you feel that you are being treated adversely for such actions, please advise a Board member immediately so that we can ensure that effective corrective and remedial action is taken. You may also contact other appropriate officials, including the U.S. Office of Special Counsel or the VA Inspector General, if you feel you are being retaliated against for your cooperation with this investigation.

6. Other Information:

AUTHORITY TO COLLECT INFORMATION: 38 USC § 5711.

PRINCIPLE PURPOSES FOR WHICH INFORMATION IS REQUESTED: To determine the facts of the matters investigated and any corrective action needed.

ROUTINE USES: The information obtained from you may be included in systems of records, including, but not limited to, "Veteran, Employee, and Citizen Health Care Facility Investigation Records," 32 VA00, and is subject to the routine uses of such systems. These uses may include internal administration of the Department of Veterans Affairs, correction of systemic problems, determination of liability for claims and benefits, administrative or disciplinary action, actions affecting professional licenses and employment, and provision of information about the matter investigated to other Federal and State agencies, Congress and the public.

FAILURE TO PROVIDE THE REQUESTED INFORMATION could lead to actions and decisions on incomplete or erroneous information. Failure to provide information by employees of the Department of Veterans Affairs could result in disciplinary action against such employees for violation of the requirements discussed above. In addition, the Department may seek to obtain information from employees or members of the public by subpoena, in which case a refusal to provide information requested at that time could be punishable in Federal court by fines and imprisonment.

7. **Members of Collective Bargaining Units (CBUs)** who reasonably believe their responses may result in disciplinary action against them may have a union representative assist them during the interview if they so request. If you are a CBU member and choose to have a representative, notify an Administrative Investigation Board member immediately so that we can provide an appropriate form for your designation.

8. **Additional Notice (if applicable):**

9. **If you have any questions or requests** regarding the matters discussed above, please notify an Administrative Investigation Board member immediately.

I HAVE READ THE ABOVE NOTICES, OR HAVE HAD THEM READ TO ME, AND HAVE HAD ANY QUESTIONS ANSWERED TO MY SATISFACTION.

Noelle Johnson PharmD, BCACP, CCP
(Print or Type Name of Interviewee)

Noelle Johnson PharmD, BCACP, CCP
(Signature of Interviewee)

3/13/15
(Date)

(Print or Type Name of Interviewer)

(Signature of Interviewer)

(Date)

DESIGNATION OF ADVISOR/REPRESENTATIVE

This is to certify that I, Noelle Johnson have designated
J. Ward Morrow, Esquire to assist me during the present
investigation.

My advisor and I will not discuss my testimony or any information gained as a result of this
investigation with others, except for disclosures specifically protected by law.

WITNESSES SIGNATURE:

SIGNED: Dr. Noelle A. Johnson PharmD, BCACP, CGP DATE: 3/13/15
Dr. Noelle A. Johnson PharmD, BCACP, CGP
(Print Witness Name Here)

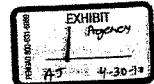
ADVISOR'S SIGNATURE:

SIGNED: _____ DATE: _____
(Print Witness Name Here)

ADVISOR IS (Check and Complete all applicable):

Union (CBU) Representative, Union/Local _____
 Attorney, Member of _____ (State) Bar
 Other, Specify relation to witness: _____

[REDACTED] - Ms Contin from QD (H)
 [REDACTED] - to BID
 [REDACTED] - α methadrene to scheduled (H)
 [REDACTED] order EKG
 [REDACTED] - convert to long acting (H)
 [REDACTED] - EKG (H) ^{rescheduled}
 [REDACTED] - Oxycontin QID - converted to methadone (M)
 [REDACTED] - conversion to long acting Morphine (W)
 [REDACTED] - advised to add breakthrough
 [REDACTED] - convert to long acting Morphine (REDACTED)
 [REDACTED] - methylphenidate SR 20mg TID BID (H)
 Victran #2 Max. 10mg/d
 Diazepam 5x/d -
 Clonazepam 5x/d -> [REDACTED] (H)
 [REDACTED] - taper OxyCodone & Morphine - Addict (D)
 [REDACTED] Converted to methadone, short acting morphine (REDACTED)
 [REDACTED] - (REDACTED) - converted to methadone, IR Morphine
 [REDACTED] - hydromorphone - Sprad nose 8mg Q4-6
 - fentanyl conversion to morphine - Pt way under
 [REDACTED] - No EKG w/ methadone converted
 Methylphenidate SR 40mg BID - (H)
 [REDACTED] - Ms contin QID
 [REDACTED] - Switch to long acting morphine V
 3



Patient to
only take 2
twice a day
clarification.

Vet ID: [REDACTED]		MEDICAL RECORD
Loc: MH-PSYCHIATRIST PTSD	Date: 03/09/08	
DOB: [REDACTED]		DOCTOR'S ORDERS
VA FORM 10-1158		

12

A) I started working at the Tomah VAMC as a Clinical Pharmacy Specialist on August 4th 2008. I officially started on the pay roll July 6th, 2008 and my service computation date was July 2nd, 2007. From August through November I was warned by many pharmacists including the previous Chief of Pharmacy Dr. Jim Due, Staff Pharmacist Kileen Larson RPh, Virginia Schroeder RPh, Dan Hanson RPh, Dave Dettle RPh, and Clinical Pharmacists Dr. Richard Schroeder and Dr. Laureen Savage-Chambers that if I question Chief of Staff Dr. David Houlihan's MD prescriptions that I would be fired. They gave me many examples of previous employees that were forced to resign or have been fired for questioning one of Dr. Houlihan's prescriptions. I was warned by all that if he did not fire me, then he would make my life very difficult at the VA. I cannot recall specific names of employees that they mentioned, however my clinical colleague Dr. Laureen Savage-Chambers and Clinical Coordinator Dr. Richard Schroeder gave the most specific examples. I did witness one of the out-patient providers Dr. Zakia Siddiqi MD be forced to resign for refusing to write a narcotic order for a chronic pain patient who's urine drug screen did not test positive for oxycodone on more than one occasion.

During this time frame I was nominated by Performance Improvement Leader Tracey Lane to be the chair of the Tomah VAMC pain committee due to my background working in a pharmacist run pain clinic in conjunction with a board certified pain specialist while in my residency at Chalmers P. Wylie VA Ambulatory Care Clinic in Columbus, OH. The interim Chief of Pharmacy at that time was Dr. Erin Narus who decided the pharmacy was too short staffed for me to spend the time necessary to be the chair of the pain committee; however, she decided I would be the pharmacy representative for the committee. (See attachment A).

B) Friday 11/21/08 I was the "hot seat" pharmacist. This pharmacist fills the window prescriptions for the patients that are waiting at the pharmacy. I received a prescription for Morphine Sulfate IR (i.e. immediate release) 15mg 7 tabs every 4 hours, 2 tablets three times daily prn (i.e. as needed) #1080 for a 30 day supply written by Dr. Houlihan. I quickly reviewed the patient profile in his medical record CPRS (i.e. computerized patient record system) to get a better assessment of what the indication for the short acting narcotic pain medication was for and to assess the type of pain being treated as well as other medications the patient had previously failed. This patient has somatic pain from a fracture of the T12, in addition to neuropathic pain with radiculopathy. After this brief assessment of the patient my initial clinical judgment was to question the short acting agent of choice and the quantity that was prescribed. After having experience working as a clinical pharmacist in a pain clinic at the VA in Columbus OH, I clinically felt this patient's pain was not being properly treated. Strictly treating a patient with only short acting medication is not the standard of care. I felt this patient would benefit from a long acting narcotic, a NSAID (i.e. non-steroidal anti-inflammatory drug), and a medication to appropriately treat his neuropathic (i.e. nerve pain) pain. I felt the short acting immediate release morphine was inappropriate monotherapy. The prescription was due to be filled on 11/24/08. The prescription was early, so I felt I had time to look into the patient's medical records to better formulate a recommendation for the provider.

I asked many of my colleagues including Clinical Pharmacists Dr. Laureen Savage-Chambers, Dr. Richard Schroeder, Dr. Margaret Hyde, and Dr. Erin Narus, and they felt the prescription was inappropriate as well. I was told not to question the order; however because it was from Dr. Houlihan and he doesn't like pharmacists questioning his orders. I was told by multiple clinical and staff pharmacists if I question the order and try to make recommendations he did not agree with, then he would try to fire me or at least make work unpleasant for me. I discussed the prescription with multiple pharmacists and I asked how the prescription had been getting filled thus far. The responses I received were statements such as, "I'm sick of fighting with Dr. Houlihan," or "I'm not calling Dr. Houlihan, I don't want to have to fight with him about anything today...good luck with that...I'm glad I'm not you," or "Last time I called and questioned an order, Dr. Houlihan called the previous Chief of Pharmacy Dr. Jim Due and told him I was trying to cause a problem."

I took the prescription to the new Chief of Pharmacy Dr. Erin Narus to review the prescription. She agreed the patient needed to be on a long acting narcotic medication as well as possibly an NSAID and a medication to treat the neuropathic pain. While I was in Dr. Naus's office I received a call from Dr. Locker MD who wanted to know if a pill identification had been done as he believed this particular patient had brought his own immediate release morphine sulfate from home and was taking this in addition to the immediate release morphine we were giving him while he was admitted to the VAMC. This would have been a direct violation of the patient's pain contract. Dr. Locher wanted to let Dr. Houlihan be aware of this violation before Dr. Houlihan wrote a new prescription for immediate release morphine upon discharge 11/21/08. The medication should have been taken away from the patient and locked up in inpatient pharmacy as this is standard protocol. This however did not happen. Dr. Locker spoke with Dr. Houlihan about his concerns with the patient and his over use of this short acting pain medication. I spoke with Dr. Locker and Berry Emerk PA-C about the pill identification. While on inpatient unit 400 observation, I showed the two providers the prescription. Both providers said, "We are glad our name isn't on the prescription." This in addition, added to my concerns about the appropriateness and safety of the prescription. The patient has built a large tolerance to this medication, which happens very quickly with short acting analgesics, and is now taking more than prescribed. This patient will likely continue to require more and more medication as he builds tolerance and dependence. Is this a case of pseudoaddiction because the patient's pain is not properly treated? Due to the fact the patient had been an inpatient for a few days and was receiving immediate release morphine in the hospital and was requesting the prescription early the patient should have had enough medication to cover through the weekend and therefore was not going to be without any medication.

My plan which was discussed and agreed upon with Dr. Narus was to go through the patients medical record more in depth and devise a plan to help convert the patient over to a long acting narcotic medication and start to taper the short acting immediate release morphine. I consulted with the Board Certified Pain Specialist, Dr. Sanhaj and Clinical Pain Pharmacist, Dr. Staci Jackson that I previously worked with in my residency to

reinforce the decision to request this patient be converted to a long acting narcotic and how to safely go about converting someone on such a large unsafe dose.

I did not have time to thoroughly go through the patients chart until Monday morning 11/24/08. All weekend long I dreaded having to make this phone call. I was afraid to call Dr. Houlihan to discuss this case after everything my colleagues had told me. I even lost sleep over it. I woke up multiple times and went over my game plan how I could tactfully and professionally approach this situation and make a recommendation to Dr. Houlihan to help him treat this patient without upsetting him, but that would safely and effectively treat the Veteran. First thing Monday morning I met with Dr. Narus and reviewed my plan with her. I asked her how to approach Dr. Houlihan knowing it was going to be a tough situation. She gave me some advice on how I could broach the subject. I had to give myself a pep talk just to pick up the phone. I have never been afraid to contact a provider to question an order or provide a recommendation before because that is my job and I know it is in the best interest of the patient. I called Dr. Houlihan's nurse Susan Schmitt and she told me he was with a patient. I told her I had a question in regards to an order, but it was an in depth question so he could call me back at his earliest convenience. The nurse ended up transferring me to Dr. Houlihan. I told Dr. Houlihan that my name was Noelle I was one of the pharmacists and I had a question in regards to the immediate release morphine order for this particular patient. I asked if Dr. Locker had spoke with him in regards to this patient taking his own morphine while admitted to the VA as an inpatient. Dr. Houlihan said he spoke with Dr. Locher. Dr. Houlihan said, "This patient did not take his own morphine while he was here." I told him I had looked through the patient's medical record and saw that he had somatic pain as well as neuropathic pain with radiculopathy. The patient had been on long acting morphine in the past. Dr. Houlihan said, "He wasn't tolerating the medication." I said, I read in the chart he was taking more than prescribed, not that he wasn't tolerating the medication." I then said I think this patient would benefit from a long acting pain medication would you consider starting him on another long acting narcotic medication. I was thinking methadone. It is a good medication for patients with somatic and neuropathic pain. This is where Dr. Houlihan began to get upset. He started to get very stern and short with his answers and he started raising his voice. He said, "The patient has addictive properties so methadone would cross the lines to addictive treatment which would need a special license." (Methadone for addiction requires a special license. Methadone for chronic pain management does not). Dr. Houlihan then asked me, "What is the bottom line, what are you really trying to say?" I said, "I clinically don't feel comfortable filling this prescription. I really feel the patient needs a long acting medication. Where are you going to go with this patient's medication regimen? The patient is going to just keep building up tolerance and greater dependence. Are you just going to keep increasing the dose?" Dr. Houlihan responded by yelling, "I'm sick of you pharmacist questioning my prescriptions. By questioning my prescription you are questioning my clinical judgment and my authority, thus by doing so are putting my license in jeopardy!" I said, "I am not trying to question your clinical judgment; I am trying to help the patient and you come up with the best way to safely and adequately treat this patient's pain." Dr. Houlihan said "Yes you are, you are questioning my clinical judgment and how I treat my patients. Some one has to see these patients and it is me." I said, "I was told you are the only one who

sees the chronic pain patients." Dr. Houlihan said, "Yes, I am the only one who can. If you don't want to fill this prescription and you want to question me all the time than you can be the one to find these patients a new Dr. to see them. How are you going to do that? No one else is going to see them! Are you going to see them?" I said, "I would like to work with you to help find the right pain regimen to treat this patient." Dr. Houlihan responded by telling me what needed to be done was, the prescription needed to be filled. I replied by telling him, "I do not feel comfortable filling the prescription and I will not do so. I would find you another pharmacist to fill the prescription, but my name will not be on the prescription because it is not in the best interest of the patient." Dr. Houlihan said he would be speaking to Dr. Narus about this situation. I told Dr. Houlihan that was fine Dr. Narus was aware of the situation. Dr. Houlihan hung up the phone.

I instantly started crying after hanging up the phone. I felt very attacked. I as well as the other pharmacists do not deserve to be treated like that. I as well as my colleagues deserve to be treated with respect, dignity, and civility. I believe Dr. Houlihan behaved in an unprofessional and threatening manner. I now know what the other pharmacists were talking about and why everyone is afraid to recommend any changes to Dr. Houlihan. I don't feel I should have to be afraid. I feel that I did what was right. I stood up for patient safety, my ethics, and protected my license. Filling that prescription was not clinically in the best interest of the patient. I feel I had every right to question the prescription and not fill it based on my clinical judgment. (See attachment B1, B2, B3).

The technician Mrs. Toni Johnson was standing next to me filling narcotic prescriptions during my phone conversation with Dr. Houlihan. Mrs. Johnson wrote a statement to attest to my professionalism. (See attachment B4).

I tried to give the prescription to another pharmacist so they may have the opportunity to fill the prescription if they chose to do so based on their own clinical judgment. The other staff pharmacists refused to fill the prescription as well once I had questioned the order. The prescription was filled by Dr. Narus.

After the phone call I went to the clinical pharmacy office for support from my fellow colleagues. They also agreed the prescription was inappropriate and that Dr. Houlihan acted in an unprofessional manner. I called Dr. Narus to tell her the conversation did not go well and she should expect a call from Dr. Houlihan. She asked if I would like to discuss what happened. I decided to contact a union representative first.

I had multiple treatment recommendations planned for this patient, but due to Dr. Houlihan's demeanor I did not have the option to discuss all of them with him.

- 1) Convert to methadone...methadone is a good option for patients who do have addictive problems because it is so long acting you do not get a "high feeling from it," it is great for somatic and neuropathic pain. We would have been using this to treat this patient's chronic pain, not an active addiction problem that I am aware of. I still believe this is a good therapeutic option for this patient. (All long acting meds are going to be hard to convert to because pt is on such a large dose of short acting morphine 720mg/d). Start to taper short acting morphine.
- 2) Pt would likely benefit from a chronic NSAID such as Etodolac since fracture of T12
- 3) Could consider retrial of long acting morphine or trial of Oxycontin or fentanyl
- 4) Could consider retrial of gabapentin. Patient had reported muscle cramps at low dose. This would be beneficial for neuropathic pain. Could consider other agent such as pregabalin or duloxetine if unable to tolerate gabapentin.
- 5) Could consider SNRI...reported ADR to venlafaxine...unknown

I then filed a grievance with the union in regards to this matter. The Inspector General was contacted in regards to a different matter. (See attachment B5). Shortly after this incident Labor and Management had a meeting. In this meeting Dr. Houlihan stated, "A pharmacist turned me into the Inspector General." I never at any point in time contacted the Inspector General.

He told the Union Steward, Diane Streeter that I acted unprofessional in regards to this specific patient matter. Diane stated, "She was not unprofessional and she has a witness who wrote a statement stating she maintained her professionalism." At this time Ms. Streeter stated she had tried to bring up the issue of starting a pain clinic and using me as an integral provider in the clinic. Per Ms. Streeter, Dr. Houlihan stated there will never be a pain clinic in this facility and if pharmacy takes over pain management then patients will start dying. If this happens patients will bring their guns to pharmacy and start shooting.

After this incident I was told by Dr. Narus and Service Line Manager, Jeff Evanson that I was no longer to call Dr. Houlihan. I was instructed to fax him my recommendations because he is unable to control his temper and faxing was Dr. Houlihan's preferred method of contact.

C) On 12/12/08 I received a prescription for a Controlled Schedule II (CII) narcotic printed on a white piece of paper from Dr. Houlihan. This prescription was a work order copy. Any employee that had computer access could have printed this prescription off CPRS. At this time the Tomah VA required all CII prescriptions to be hand written by the provider on the green prescription pad assigned to each individual provider. Some VA's were transitioning to using the computerized form of a CII prescription. This prescription was printed as a work order, not a computerized CII prescription. As far as I and the other pharmacists were aware we were still requiring the green prescription copy. I tried paging Dr. Narus multiple times and did not get a response. The patient was waiting for the prescription to be filled and was irritated it was taking so long. I decided to go to Dr. Houlihan's office to ask his secretary to have Dr. Houlihan rewrite the CII on the green copy. Dr. Houlihan's office door was open and he heard me talking to his secretary. Dr. Houlihan came running out of his office yelling at me. He said, "This is a legitimate prescription and I will not rewrite the prescription. He yelled I am so sick of you F...ing pharmacist! I want to speak to Erin Narus immediately!" He marched down to out-patient pharmacy and I paged Dr. Narus again to come to the pharmacy. Dr. Narus and Jeff Evanson came to the pharmacy and had a meeting with Dr. Houlihan in the back. I went back to filling prescriptions and I could hear Dr. Houlihan maligning me. I was never brought into the discussion to defend myself. As it turned out Dr. Narus and Dr. Houlihan had made a prior agreement that Dr. Houlihan would start to write the CII prescription on the computerized from due to a previous confrontation he had a week prior with another pharmacist in regards to misspelling a patients name 3 times. This change was not communicated with any of the pharmacists. The prescription still had to be rewritten as requested due to the fact it was a work order, not a prescription written and printed correctly from CPRS. On 12/15/08 Dr. Narus handed out a new hard copy guideline exclusively for Dr. Houlihan. (See attachment C New Schedule II order Entry in CPRS for Out-Patient-Pharmacy).

D) February 2009: New Chief of Pharmacy Dr. Tom Jaeger and Dr. Savage-Chambers attend a Medical Executive Meeting. In this meeting Dr. Houlihan again told everyone that I turned him into the Inspector General. Both parties told Dr. Houlihan that I did not turn him into the Inspector General.

E) February 6th I had a meeting with Dr. Jaeger and Union Steward Diane Streeter. This meeting was to discuss the verbal threat Dr. Houlihan made in the Labor and Management meeting. In this meeting Dr. Jaeger gave me suggestions of agencies to contact with my concerns. He gave me the paper work for the Inspector General and JACCHO. Dr. Jaeger explained, he thought JACCHO was the best avenue to pursue for reporting the unsafe practices of Dr. Houlihan.

At this point Dr. Jaeger assigned me to the VISN 12 (regional level) Pain Committee. I was also assigned as the leader of the Opioid Work Group by Tracey Lane from performance improvement.

F) On March 9th, 2009 I received a prescription from Dr. Houlihan for Methylphenidate Sustained Release 120mg/day. The max dose of this narcotic stimulant medication is 60mg daily. I reviewed the patient's medical record and discovered the patient had previously been on this dose. I also noted the patient had a strong cardiac history. I did not feel this was a safe dose for the patient. This medication is a lipid soluble medication. If given too high of a dose the medication could over saturate the enzymes used to break the medication down and therefore build up in the patient's system and potentially cause harm such as a cardiac arrhythmia due to the stimulant properties. I faxed Dr. Houlihan and asked if the dose could be reduced or if the medication was not beneficial at a lower dose if he could choose an alternative agent for the patient. Within a couple of days Dr. Houlihan wrote a new order for the same dosage and commented on the prescription. "Pt is a large man, fill as is." This medication is not weight based for adults. Dr. Savage-Chambers and I resourced with colleagues at the VA in Madison to see if any doses greater than 60mg have ever been filled. One prescription had been filled for 70mg, other than that dose above 60mg had not been filled. I consulted with many of the clinical and staff pharmacists and they all felt the medication dose was unsafe. I gave the prescription to my previous Interim Chief of Pharmacy, now Out-Patient Supervisor Dr. Narus who also agreed the medication dose was unsafe. Dr. Narus was going to talk to Dr. Houlihan. A few days had gone by and nothing had been done with the prescription. Dr. Narus was called away from work for personal reasons. I received a call in clinic from one of the out-patient staff pharmacist Kalleen Larson, RPh. She stated, "The patient is coming to pick up his Methylphenidate and Erin would like the prescription to be partially (see definition below) until further clarification from Dr. Houlihan. I want nothing to do with this prescription you need to come over to out-patient and fill this prescription." Dr. Narus had written directions on the prescription to give a 7 day supply. There was also a yellow note stuck to the prescription that stated I was to tell the patient to only take 2 tablets twice daily until further clarification from Dr. Houlihan. There were two separate problems at hand. It is illegal to partial a CII narcotic prescription unless you do not have sufficient quantity to dispense the total and then you only have 72 hours to dispense the remaining or the rest of the prescription is null and void. (See attachment F1). It is also illegal and unsafe to tell the patient to take different directions than what is written on the bottle or what the provider has prescribed. (See attachment F2).

I was not going to illegally partial a prescription and I was not going to tell the patient to take different directions than what the Dr. had prescribed. Dr. Jaeger was out of the office and now so was Dr. Narus. I brought the prescription to my Service Line Manager, Mr. Jeff Evanson who is not a pharmacist or licensed professional. Mr. Evanson's response was, "Why are you trying to cause trouble?" I explained that I wasn't trying to cause trouble, that this was an unsafe dose for the patient and I was not going to illegally fill the prescription as I had been asked to do. He stated, "Why are you trying to throw Erin under the bus?" I again explained that was not my intention, but the patient was coming to get the prescription at the pharmacy and neither Dr. Narus nor Dr. Jaeger were available. I was not going to fill the prescription at the unsafe dose. I was unwilling to fill it illegally and the other pharmacists were not going to fill the prescription either. Mr. Evanson responded by saying, "If Dr. Houlihan said to fill the prescription you will fill it. You have no right not to!" I responded by saying, "I am an individually licensed

pharmacist. I am 50% liable for anything that happens to that patient. I in good conscience cannot fill that prescription just because a provider thinks that I should. It is my job to make sure that prescription is safe for the patient to take. If something were to happen to this patient I am liable and I am not willing to compromise patient safety and my ethics. Mr. Evanson and I continued to debate the issue for over an hour. Mr. Evanson stated, "How dare you claim to be an expert! He asked, why have the other pharmacist filled the medication so far?" I explained that the other pharmacists told me they were told not to question Dr. Houlahan's prescriptions and they were afraid they would be fired if they made a recommendation he did not agree with. I then told Mr. Evanson that Dr. Houlahan could fire me, but I was going to stand up and do what was right and safe for the patient. I was not, and will never be willing to compromise patient safety and my ethics. Mr. Evanson responded by saying, "Houlahan doesn't have the authority to fire you, only I can make that decision." The conversation ended by Mr. Evanson asking to speak with my Clinical Coordinator Dr. Schroeder. Dr. Schroeder, Dr. Savage-Chambers and Union Steward Peggy Burke attend a meeting with Mr. Evanson. Both clinical pharmacist supported and clinically agreed with my decision. Dr. Savage-Chambers wrote the error up in our good catch log. This is a log of provider errors that are kept track of. The patient did not receive the medication that day. When Dr. Narus returned she spoke with Dr. Houlahan and the order was changed to 60mg total daily dose. (Documentation of prescription and note to partial the prescription and change directions is on file with the Tomah VA Union Office).

G) After this incident Dr. Jaeger asked me to write a standard operating procedure (SOP). He wanted me to write a procedure that stated if the provider disagreed with the clinical recommendation that we had to fill the prescription as is. If the pharmacist documented they clarified the prescription then the liability was no longer placed on the pharmacist. I disagreed with this and did not feel comfortable making the SOP without legal advice. I called the Iowa Board of Pharmacy. They advised me that the pharmacist is still liable for those prescriptions even if there is documentation of clarification. They advised me to not fill anything that was unsafe for the patient. They also recommended I contact Inspector General as it seemed we had a problem in the Tomah VAMC. I gave Dr. Jaeger this information and wrote the SOP accordingly. (See attachment G).

H) March 30th, 2009 Janice Waldstein a NP from the Wausau Community Based Out-Patient Clinic (CBOC) emailed Dr. Jaeger to compliment my professional abilities and report our positive interactions over the previous 5 months she had worked in the CBOC. Dr. Jaeger responded by saying, "Thank you for the feedback. I agree that Noelle is an exceptional pharmacist. It is always nice to get this sort of feedback to assure her that her work is appreciated. Thanks." (See attachment H)

I) May 12th, 2009 I attended the Tomah VAMC pain committee meeting. While in this meeting the new chair of the committee Dr. Whiteway MD told us that some key stakeholders would be having a meeting in regards to a proposal for starting a pain clinic. He named some of the key stakeholders which included himself, Deb Frasher co-chair, Dr. Houlahan, Associate Chief of Staff, Dr. Picca MD and then he said, "And your colleague Dr. Margaret Hyde. I don't know her. Why would she be asked to attend?" I

didn't explain the situation at the current time as there were many people around and it was not the appropriate time or the place. After the meeting I explained to Dr. Whiteway that Dr. Houlihan and I didn't exactly see eye to eye. I gave him some of the examples of the prescriptions I felt were unsafe for the patient and consequently refused to fill, as well as some other examples of questionable practices. I also explained that another clinical pharmacist Dr. Margaret Hyde had been consulting with Dr. Houlihan on some of his pain patients. Dr. Whiteway told me he received an email that said I was not to attend the meeting and that he was to find another pharmacist. At this time Dr. Houlihan named Dr. Hyde. At this time I told Dr. Whiteway and Deb Frasher NP that if Dr. Houlihan is unwilling to work with me that it might be in the best interest of the patients and the committee if I step down. They agreed and Deb Frasher told me that I could work from behind the scene to help the patients and Dr. Hyde. Approximately seven months prior Dr. Hyde approached me in front of Dr. Savage-Chambers and asked me to teach and guide her in relation to managing diabetic and chronic pain patients.

May 15th, 2009 I then set up a meeting with Dr. Jaeger and Dr. Hyde. At this time we all agreed for consistency purposes it needed to be the same person on all committees and clinics. I told Dr. Jaeger and Dr. Hyde that if the support wasn't there from the Chief of Staff to be on the pain committee and in the pain clinic, then I didn't feel I should be following the individual pain patients that I had been making recommendations on. They both agreed and Dr. Jaeger assigned Dr. Hyde to all the committees in my place. I then gave Dr. Hyde a list of the few patients I was still following for specific providers. She agreed to take over the monitoring of these patients. Most of these patients were now stable so they could have been sent back to primary care.

J) May 27th, 2009 I received a prescription from Dr. Houlihan for a prescription that was written for 1,447mg of Morphine equivalent. This was a 100% increase in dose for this patient. I knew this patient was a difficult patient and that Dr. Hyde was working on this patient with Dr. Houlihan. I reviewed the medical record with Dr. Savage-Chambers and there was no documentation at the time as to why Dr. Houlihan was increasing the dose 100% or that the plan was to admit the patient for observation on June 1st. Dr. Hyde did not have a pager at the time and was in an infectious disease meeting. The patient again was waiting so I called Dr. Hyde in her meeting. I asked Dr. Hyde why they were doing 100% increase. I said, "In most cases a 100% increase at such a high dose is contraindicated. Why would Dr. Houlihan do a 100% increase if a 25% increase would have been beneficial. Dr. Hyde then raised her voice at me and said, "You don't know what you are talking about, I have been in practice a lot longer than you. Just because you worked in a pain clinic doesn't mean you have seen everything. The patient increased the dose 100% on his own!" The prescription was then filled. Five minutes later I saw Dr. Hyde in the hallway. She stated, "They are going to admit that patient for observation on Monday." I then asked her why we gave him a 30 day supply of a narcotic medication at that dangerous dose if he was going to be admitted as an inpatient in 4 days, especially if he was self escalating his dose. I also told her after looking back at his refill history that even at the 100% increase he should still have enough medication to last until Monday. Dr. Hyde then walked away. The patient was not admitted on Monday June 1st.

K) The first week of June I asked Dr. Jaeger if I could be taken off the 9-5:30pm shift. I rotated this shift with two other pharmacists. I was hired on as a Clinical Staff Pharmacist. I worked two days a week in out-patient pharmacy and three days a week in the out-patient clinic. When I was hired I was told the intention was to hire me as a full time clinical pharmacist, however that is not the position that had open and they would be back filling a staffing position. I then became 60% clinical and 40% staffing. When I was hired I was told my tour of duty would be a temporary shift and the least senior and last person hired would have to work the 9-5:30pm shift. Beginning of June and July two new staff pharmacist were hired. This shift started to interfere with my clinic time as my colleagues in the clinic would start at 8am and I would then be an hour behind on my work and I was putting in overtime to catch up. I set up a meeting with Dr. Jaeger and asked what the possibilities would be if I could be taken off the shift since the two new pharmacists were going to be starting and I was told it was a temporary shift. Dr. Jaeger responded, I don't know I will have to look into it since this shift was made before I got here. I then told Dr. Jaeger and Dr. Narus that I would volunteer to stay on this shift until the two new pharmacists were trained. I also told this to the Inpatient Clinical Staff Pharmacist, Dr. Heather Ashmus that was making out the new schedule. A few days later I received a call from Dr. Jaeger and he said, "Effective immediately you are no longer on the 9-5:30pm shift." I then again told Dr. Jaeger and Dr. Narus that I would be willing to work the shift until the two new pharmacists were trained. Dr. Narus said, "Forget it; it is too much of a hassle."

Dr. Ashmus was then sent an email telling her, she was to pick up most of my shifts. No one volunteered to take the shifts like the report of contact stated, and I never refused to work the shift. Dr. Jaeger then told Dr. Ashmus that this was an unapproved shift and it never went through the union so if I wanted to I could cause a problem and that someone had turned him into the union in regards to unapproved shifts. (See attachment N3).

I never filed a grievance or even discussed the matter with the union in regards to this shift.

L) Beginning of June I was contacted by Drug Enforcement Administration; DEA investigator Thomas Hill and asked to comply with his investigation regarding Dr. Houlihan. I agreed to meet with Mr. Hill (414-839-5682) and did so on June 19th, 2009. I met with Mr. Hill and my parents at my apartment in Tomah for about 2 hours. I gave Mr. Hill examples of about 10 of Dr. Houlihan's patients and the unsafe narcotic prescriptions he was prescribing. The examples included the unsafe doses, duration, and quantities of these narcotics which are listed in this report, in addition to examples I was not specifically involved with. We also discussed the 3 unexplained suicides at the VA over the last couple of months. All of which were Dr. Houlihan's patients. I gave Mr. Hill the names of another pharmacist and private physician who wished to help in Mr. Hill's investigation. Mr. Hill informed me the Attorney General would likely be speaking with me. He said he would be asking for an immediate suspension of Dr. Houlihan's DEA License. I was advised not to fill anything I did not feel was safe for the patient or anything that was outside of the normal scope. Mr. Hill informed me he would be in contact.

M) June 8th, 2009 I received a prescription from Dr. Houlihan for the narcotic Dextromethamphetamine Sustained Release 30mg three times daily. This is usually a once daily medication. It could at times be a twice daily medication if it wasn't lasting long enough, however it should not be used three times a day. The short acting medication is used three times daily instead. Like the Methylphenidate prescription the max dose was 60mg/day. It has very similar pharmacokinetic properties. I again felt uncomfortable with the dosage and the duration. I initially filled the prescription because I was so sick of fighting. By the time the prescription got to the front of pharmacy I felt so guilty and afraid it may harm the patient. I took the prescription back and discontinued the computer order because my name was on the prescription. I kept the hard copy intact. I brought the prescription to the attention of Dr. Savage-Chambers for advice. She agreed the prescription was not appropriate. At this time I went back to the pharmacy to speak with the patient. The patient said he was taking the medication because he could not focus. This patient had a diagnosis of schizophrenia and that was the indication listed in his medical record. This medication is cautioned in such patients especially at high doses. It can cause hallucinations and mania and the studied dose was listed as 10mg daily per multiple drug references. The patient presented with both of these symptoms. The patient had enough medication to last until the 11th so I told the patient I did not feel comfortable dispensing this medication and there was a question in regards to the safety of his dose. I wanted to look into more research before making a decision. The patient was in agreement with this plan, however his wife got very upset and called Dr. Houlihan's nurse Susan Schmitt. In the mean time, Dr. Savage-Chambers had sent an email to Dr. Jaeger asking if the medication could be reviewed by Dr. Picca who is the head of Pharmacy and Therapeutics Committee as Dr. Houlihan was out of the office. In the mean time Dr. Houlihan's nurse called me and told me I was to fill that prescription and that Dr. Houlihan was not available for consultation. I told her I was aware, and the prescription was going to be reviewed by Dr. Picca. She said, "Dr. Houlihan would not be happy about this and you should just fill the medication as the patient has been on this dose before." I explained to her again, I was not going to fill the medication until I could look into the toxicology further to make sure it was safe for the patient.

I asked Dr. Narus if she would fill the prescription. she declined. She agreed it should go to Dr. Picca for review.

The next day I started looking into the toxicology information and more in depth in the patient's medical record. I observed a note scanned into this patient's chart from an outside physician. This physician claimed to be following this patient for his chronic pain. The outside physician was prescribing long acting narcotic Oxycontin **twice** daily for the patient. The patient had a recent drug test and he tested positive for methadone, another long acting pain medication. This patient claimed that he was on methadone a long time ago. The patient never received methadone from any VA. The medication is very long acting, however it should not show up in a urine drug test after about 3-9 days after discontinuation depending on length of therapy and varying references. (See attachment M). The patient also claimed he was taking his amphetamine "prn" (i.e. as needed) The provider asked the patient to come back and do another drug test. The patient did not have one done, so the outside provider was discontinuing his Oxycontin.

Dr. Houlihan wrote Oxycontin for this patient **three** times daily. I started to look at the refill dates listed in the letter scanned from the outside provider and the dates the patient was getting Oxycontin from the VA. The refill dates were only a week or two apart for a 30 day supply. The patient was again in violation of his pain contract and this allowed me to believe the patient was diverting the narcotics and taking other narcotic prescriptions illegally. In addition, a while back this same patient left his cell phone in pharmacy by accident. The Staff Pharmacist, Dave Dettle, RPh picked up the phone and on the other end a man was trying to buy medication from this patient's phone.

I printed this information and highlighted it and gave it to Dr. Jaeger who decided to still fill the prescription as is per Dr. Picca's request on June 12th. When I gave the information to Dr. Jaeger, he just looked at me and said, "Whatever!"

N) June 16th, 2009 at 4:10pm Dr. Jaeger took me in his office and said, "You are going to be fired as of 4:30pm today. They were going to fire you on Friday June 19th, but for some reason they are going to fire you today instead." He proceeded to tell me he thought that I was a wonderful pharmacist and I was just too progressive for this place. I was going to make a great clinical pharmacist for some other facility. He stated, "I will write you a letter of recommendation and I will stand up for you. I will defend you." He proceeded to give me his cell phone number and his personal email. Dr. Jaeger then told me, "If you let them fire you than you will be deemed unfit for federal employment and I don't want to see that happen so I hope you will resign. You have to make a decision by 4:30pm today." I asked, "Why am I being fired." Dr. Jaeger told me there were some reports of contact. I asked, "From whom?" He stated, "I was one of them. I didn't mean it, and I tried to take it back, but it was too late. I wanted to take the report of contact back, but it was taken off of the Interim Service Line Manager Susan Robinson's desk." He then proceeded to explain that neither Susan Robinson nor he knew that I was going to be fired. Dr. Jaeger stated, "I thought there was going to be a performance improvement plan made." Dr. Jaeger then stated, "Please don't let them fire you." Dr. Jaeger then asked if I wanted him to write my letter of resignation, I agreed, and he wrote my letter of resignation on his computer. He replaced his information on a pre-written letter of resignation with my information. he then stated, "I'm resigning as of June 26th. I am not going to put up with this. What happened to you was wrong. I don't want to work for an organization like this. I am done with the Federal Government forever." I then went to Susan Robinson's office to hand in my resignation and she told me I needed to go to Dave Dechant's office in human resources.

I proceeded to Dave Dechant's office accompanied by Union Stewards Diane Streeter and Peggy Burke. I gave Dave Dechant my resignation form. Dave then said, "You do not have to make this decision to resign or be terminated until June 30th" I then took my resignation form back. He proceeded to give me a memo of separation (See attachment N1). I asked Dave for an explanation of why I was being terminated. He stated, I was in my probationary period and based on "performance issues" I was not going to become a permanent employee. Dave gave me copies of two reports of contact. One was from Dr. Margaret Hyde and the other was from Dr. Tom Jaeger (See attachment N2 and N3). I asked Dave how this could be done. I was never given a verbal or written warning on

anything and both of my performance evaluations were fully successful (See attachment N4). The reports of contact were not verified and were not truthful. Dave responded by saying, "It doesn't matter they didn't have to warn you because you are still in your probationary period." I later discovered my probationary period end date was July 6th 2009. At that point in time I was to return to work the next day. Peggy Burke and Diane Streeter asked for me to be given one day of authorized absence to pull myself together before returning to work.

I then proceeded to the union office where I received a call from Dave Dechant. I was then granted authorized absence until June 30th and I had to hand in my keys and badge. At this point all of my computer access was terminated. I was not given the opportunity to obtain my personal files and literature documents that I had brought with me from the previous VA I had transferred from.

Later that evening I had a 2 hour phone conversation with Dr. Jaeger. Dr. Jaeger told Dr. Ashmus, my mother MAJ Johnson, and I that he felt coerced into writing the report of contact and if he could, he would take it back. He agreed to write a retraction statement.

O) June 17th MAJ Johnson, Dr. Jaeger, Union Steward Diane Streeter and I had a meeting. Dr. Jaeger again stated he did not know who fired me. He stated, "Neither Susan Robinson or I fired you." He also stated again, "I felt coerced into writing the report of contact and if I could, I would take it back." He said, "I will be glad to write a retraction statement." Dr. Jaeger also stated at this meeting Dr. Houlihan still thinks I turned him into the Inspector General. At this time Dr. Jaeger also reported, "I think Dr. Houlihan acts like he is on a cocaine high."

P) June 17th I had a meeting with Human Resource Coordinator Dave Dechant, MAJ Johnson, and Union Steward Diane Streeter. Dave Dechant told us that I turned Dr. Houlihan into the Inspector General. I again told him I never turned Dr. Houlihan into IG. Dave Dechant said, "You were fired based on a committee decision compiled of upper management." He would not say who made up this committee or divulge who made the actual decision for termination. He did report it was not Susan Robinson who brought him the reports of contact. I also asked for the VHA directive that states a probationary employee can be fired with out any verbal or written warning. Mr. Dechant was unable to provide such a VHA directive for probationary employees. Mr. Dechant stated he contacted Milwaukee Human Resource department who was also unable to provide such documentation or any directive related to termination of a probationary employee.

Q) June 17th, Dr. Houlihan called a meeting with the two least senior pharmacists. This included Dr. Heather Ashmus and Out-Patient Staff Pharmacist Rebecca Bell. In this meeting he professionally slandered me by discussing the terms and conditions of my termination as well as the differences we incurred. He fabricated information by telling them I threw papers in his face and that he was a Board Certified Pain Specialist. He told them he was not the one who "pulled the trigger" on me. These were interesting choices for words considering Dr. Houlihan threatened about patients shooting the pharmacist

who took over pain management while in a labor management meeting with Union Steward Diane Streeter. (See attachment Q).

R) June 18th Dr. Jaeger resigned from the Tomah VA. Dr. Jaeger had Dr. Ashmus help him clean out his office prior to leaving June 17th. Per Dr. Ashmus, Dr. Jaeger stated I'm done with this place, I'm not ever coming back. I will not stand around and take the fall for Noelle's termination. On the 18th I attempted to contact Dr. Jaeger on his cell phone to ask for the retraction statement he said he would write. Dr. Jaeger did not answer or return my message. I have not contacted him since.

S) June 23rd I had a meeting with Associate Director Sandra Gregor, Human Resource Coordinator Dave Dechant, and Union Steward Kurt Hass. Sandra Gregor reported I was fired based on the reports of contact and the recommendation from Chief of Pharmacy Dr. Tom Jaeger. Dave then gave me a copy of a new report of contact that Dr. Jaeger had written. This stated he would not retract his previous report of contact. He stood by his decision that my performance was considered unsatisfactory due to refusing to fill multiple prescriptions. (See attachment S1).

I told Sandra Gregor I would like to write a report of contact on the professional slander Dr. Houlihan had made. She responded by saying, "That is your word against his and the other pharmacist." I said exactly! I was fired for reports of contact that were falsified and never verified. I was never given verbal or written warning, or the chance to defend my position. She then stated, "I stand by the decision for termination." Immediately after my termination and Dr. Jaeger's departure the pharmacist who wrote one of the reports of contact Dr. Hyde was appointed to the position of Acting Chief of Pharmacy. (See attachment S2 and S3).

Attachments:

- A) Nomination for Tomah Pain Committee Chair from Performance Improvement
Tracey Lane.
- B) 1) Clinical Practice Guidelines for the use of Chronic Opioid Therapy in
Chronic Non Cancer Pain. Journal of Pain, Vol 10, No 2, February, 2009: pp 113-
130
2) VA/DOD Clinical Practice Guidelines for the Management of Opioid Therapy
for Chronic Pain. Medication Pocket Guide. <http://www.qm0.amedd.army.mil>
3) Methadone Dosing Recommendations for Treatment of Chronic Pain.
<http://www.vapbm.org>
4) Technician Toni Johnson Statement
5) Questions for Leadership from the American Federation of Government
Employees; Presented to Inspector General
- C) New Schedule II Order Entry In CPRS for Out-Patient-Pharmacy
- F) 1) Iowa Board of Pharmacy Controlled Substance Law on partial filling a CII
2) Drug Enforcement Agency Diversion Control Program laws regarding what
changes a pharmacist can make on a CII prescription.
- G) Standard Operating Procedure: Prescriptions Under Clarification
- H) Email from Nurse Practitioner Janice Waldstein
- M) Urine Drug Screen Practical for Clinicians. Mayo Clin Proc. 2008;83(1):66-76
www.mayoclinicproceedings.com
- N) 1) Memo of Separation
2) Report of Contact from Margaret Hyde
3) Report of Contact from Tom Jaeger
4) Noelle Johnson Performance Evaluation
- Q) Statement of Professional Slander from Heather Ashmus and Rebecca Bell

- S) 1) Tom Jaeger's second Report of Contact
- 2) Medical Center Bulletin
- 3) Department of Veteran Affairs Memorandum

T) Character References (1-12) from Clinical Pharmacists, Staff Pharmacists, Pharmacy Technicians, and Providers.

U) State of Wisconsin Department of Workforce Development, Division of Unemployment Insurance

Johnson, Noelle A.

From: Lane, Tracey
Sent: Friday, November 28, 2008 1:13 PM
To: Narus, Erin Y.
Cc: Houlihan, David J.; Broad, Judith E.; Ten Haaf, Patricia L.; Johnson, Noelle A.
Subject: Request for pain person

Follow Up Flag: Follow up
Flag Status: Red

Erin,
Good afternoon! I would like to recommend Noelle Johnson, who is a pharmacist to join our pain management committee as the chair. Pain is a major component and focus for Joint Commission and VA nationally. Our group would greatly benefit from a clinician who has experience, interest, and expertise in pain. I would like to propose that Noelle has some time set aside for pain management committee duties.

I was very impressed with Noelle during a grand round presentation on pain. Although, Noelle did not present the material she provided wonderful information and sparked discussion surrounding pain issues from her previous experience. In addition, during a recent VISN 12 face-to-face meeting, much of the recommended education from providers is about the dosage of pain medications. Pharmacy is an important component for effective pain management.

Thanks,

Tracey Lane MSN
VAMC Tomah
Performance Improvement
ext. 66014

Please consider the environment before printing this e-mail

Attachment A

Streeter, Diane H.

From: Johnson, Toni A.
Sent: Tuesday, November 25, 2008 10:20 AM
To: Streeter, Diane H.
Subject: Noelle Johnson telephone call 11/25/08

I am providing this statement in regards to a telephone conversation that I overheard on 11/24/08 between Noelle Johnson and another party.

I am not sure how long the conversation had been in progress before I entered the area to work. Noelle's demeanor was professional and helpful and I did not hear her raise her voice at any point. I heard her offering help and suggestions for alternative therapy possibilities. I would not have thought anything was out of the ordinary with this conversation, except at the close of the phone call, when she hung up the telephone, she burst into tears.

Toni A. Johnson



American Federation of Government Employees
 Affiliated with AFL-CIO
 Local 1882
 V.A. Medical Center/Fort McCoy
 Tomah, WI 54660

Date: April 17, 2009
 From: AFGE Local 1882 AFL-CIO
 Subject: Issues at V. A. Medical Center, Tomah, WI
 To: Ben Balkum, President
 AFGE Local
 V.A. Medical Center
 Iron Mountain, MI

Hello Ben,

1. I understand that you will be visiting some of our Representatives on Capitol Hill the week of April 19, 2009. I am writing with the hope, time permitting, you will be so kind as to inform our Representatives of some of the more significant concerns AFGE LOCAL 1882 Officers, and many others, have concerning care of the Veteran patients at this health care facility.
2. **Providers' Privileging/Credentialing:** Some months ago, AFGE learned that this Agency is forcing unsolicited Privileges/Credentials upon the Providers who work here. Example: Providers (M.D., Ph.D., Physician Assistants, Nurse Practitioners) apply for a position at this Medical Center and there is an agreement between the Chief of Staff and the Providers that they will work as an outpatient provider in the Ambulatory Care Outpatient Clinic, Monday through Friday, administrative hours. The Provider accepts the position and moves here. Once on board, the newly hired Providers are handed a different set of Privileges/Credentials and told to sign them. The Providers will state that the Privileges/Credentials are not what he/she agreed to prior to being hired. Regardless, the Providers are forced to sign the new Privileges/Credentials, or lose their jobs. This has meant that Providers who have come here must work: Outpatient; in addition to Inpatient and Urgent Care --- which also means they are working off-shifts.

These Providers become anxious and concerned since many of them have not worked Urgent care since their Residency. At this facility, there are extremely ill patients presenting at Urgent Care – and we do not have an Emergency Room nor an ICU. Therefore, often times, the patients who present to Urgent Care are more like Emergency Room candidates. And, again, the Providers I speak of have specialty in outpatient clinic patient care; therefore, it is often time the Urgent Care RN's who are re-orienting the Dr.'s to the Urgent Care needs of the Veteran patients.

Another example of forcing privileges/credentials on Providers is: A memo is prepared by administration which reads: 'I am requesting the following additions to my clinical privileges---"Ventilator Management," etc. The canned memo is handed to the provider for their signature. Typically, the Provider will respond: "There must be some mistake. I did not request these privileges." They will be told --- "You must sign the paperwork!" Keep in mind that many of the outpatient providers will not have worked with ventilators since perhaps residency years and yet are expected to be competent after signature on a memo and viewing a 20 minute video.

3. A second serious concern is the fact that many of the Veterans served at this facility are **prescribed large quantities of narcotics**.

There are providers and Registered Pharmacists who refuse to prescribe or to fill large quantities of narcotic prescriptions as ordered by the Chief of Staff, Dr. David Houlihan. It is a known fact that if the providers or pharmacists refuse to follow Dr. Houlihan's orders, they will be yelled at and perhaps fired. Quite recently a Pharmacist refused to fill an order for 1,000+ narcotic tablets for a 30 day supply for one of Dr. Houlihan's patients --- the Pharmacist viewed the order as "unethical." This Pharmacist received a verbal thrashing from the Chief of Staff. (Many providers have left because of the harassment). This type of pressure makes it difficult for the providers to "do the right thing" for the patients.

If some of the patients do not receive the narcotics they request, they will go to the Patient Advocate and file a complaint against the Provider. (NOTE: The 2 Agency Patient Advocate positions report directly to the Chief of Staff, which appears to be an conflict of interest and unethical.) When a patient visits the Patient Advocate with a complaint against a Provider, this is tallied against the provider and viewed as a "negative event." Recently, a Provider was terminated/fired because she received "too many complaints." Some of these complaints were due to the fact she would not reorder narcotics for some of the patients who appeared to be at risk for further addiction/abuse. Additionally, this same Provider challenged the fact that she was forced to signed Privileges/Credentials she did not agree to prior to being hired.

The Chief of Staff has instructed the providers they are not to do "urine/drug screens" prior to ordering narcotics for patients, because the screening can be "inaccurate." For example, if a Veteran patient had been prescribed narcotics and came in early, prior to renewal date, to get more of the prescription narcotic, there could be reason to question what may be happening with the drugs; and, in some cases Providers may have ordered a urine/drug screen. A urine screen could show if the patient is or is not ingesting the medication. A clean, or trace, urine could very well indicate the Veteran patient is not him/herself actually consuming the narcotics. There are several Veteran patients with narcotic contracts here --- regardless, very often these veterans are able to continue to receive narcotics most times they request. To the best of my knowledge, most Providers – per instruction – no longer order urine/drug screens as an assessment tool prior to ordering/re-ordering narcotic medications.

Many of the patients call Dr. Houlihan "The Candy Man" because of the easy access to narcotic drugs/medications at this facility.

There have been several unexplained deaths at this Medical Center. In 2008, there were three (3) suicides of veterans while sitting in parked vehicles on the Medical Center grounds. These patients were counseled by Psychiatrist/Chief of Staff Dr. David Houlihan.

Please know we have many concerns for our Veterans and for the Employees. I have taken the liberty to attempt to explain two (2) of the most significant concerns at this time. If you are able to assist the Veterans, AFGE and many others will be eternally grateful. If, on the other, there is a different venue I should be taking; e.g., contacting the Office of Inspector General – please so inform and I will do what it takes to ensure a safer care environment for our U.S. of A. Warriors.

Respectfully Submitted,

Lin Ellingshuisen
Executive V.P./Chief Negotiator / Steward
AFGE LOCAL 1882 AFL-CIO
V. A. Medical Center
500 E. Veterans Street
Tomah, WI 54660
W - (608) 372-3878
C - (507) 459-9669
Fax (608) 372-1689

QUESTIONS For LEADERSHIP

1. Why is the Chief of Staff allowed to create a hostile working environment?
 - a. There have been complaints from health care staff --- they are afraid that Dr. Houlihan will get them fired. ...as he has disciplined/or made life difficult for many providers (Dr.'s, Nurse Practitioners, Physicians Assistants) as well as Nursing staff.
 - b. Why is it that so many providers (psychiatrists, psychologists) don't stay here for long? (It is because they won't put up with Dr. Houlihan's yelling and threatening behaviors.)
 - c. It is reported that Dr. Houlihan doesn't physically/personally see and evaluate the inpatients on Acute Mental Health unit from their date of admission up through their day of discharge. ??Does Dr. Houlihan merely write patients' prescriptions without physically assessing the patients?
 - d. Some employees have reported that several inpatients have asked Dr. Houlihan when he will evaluate them and the Dr. will tell the veteran that he will be back later or at a specific hour of the day or night. Most often the Dr. does not show up! There have been veteran inpatients who have not gone to the dining room to eat a meal, as they sit by the elevator because they don't want to miss Dr. Houlihan's entrance onto the unit. Nursing staff have brought the patients their dinner trays as the patients wait by the elevator!
 - e. There have been reports that Dr. Houlihan, after being off work for days/weeks, will re-write patients' prescriptions/orders without physically being present and re-evaluating the patients. (This most frequently occurs when Dr. Houlihan has been gone and there has been a visiting psychiatrist working in his place. Dr. Houlihan will re-write these orders from his home.) Dr. Houlihan does not telephone the nursing staff for an update on the patients' conditions. In fact, the nurses only learn of the medication changes by happenstance/by luck!
 - f. Why does Leadership allow Dr. Houlihan to yell and scream -- sometimes profanities, - at the providers and the nursing staff?
 - g. It has been reported that Dr. Houlihan was involved in a witnessed event wherein he verbally abused a patient. We understand that the VISN/Regional Office did an investigation. What was the outcome of that investigation? (There were 5 staff who witnessed this --- and nothing was done about it! Dr. Houlihan yelled at the patient; got in the patient's face; and forcefully several times knocked his leg against the patients knee. This was a psych patient, debilitated, and sitting in a wheelchair!)

2. Union Officers informed us that at a Labor/Management meeting on or about May 2007, Stan Johnson, former Director, informed all in attendance that Nursing had received \$8 Million dollars for staffing. It is a question for many V. A. employees as to where the money was spent! What was this money requested for? What was it spent on? (This Agency is short staffed – by approx. 25-30 RN's at time of this writing.)
3. Per some workers, there was money allocated for Neuro Virus vaccine – but instead of putting money towards the vaccine --- a flashing sign was purchased and placed outside bldg. 400, Admissions Bldg.

August 7, 2008

1. There have been several staff reports that Dr. Houlihan is known as the “candy man” by several patients here. There are several staff whom, in their professional judgement, believe that Dr. Houlihan overmedicates patients. There have been several patients who have had to be given Narcan due to adverse side affects from too many narcotics and other medications.
2. Dr. Houlihan, early December 2008, screamed at a Registered Pharmacist, who used to be the Coordinator of a Pain Clinic at another health care agency, because she recommended to him a different regimen of pain medications. The Pharmacist refused to fill the prescription because the patient would have overdosed on narcotics.

January 2009

Noelle J.

New Schedule II Order Entry in CPRS for Out-Patients-Pharmacy

- No more blue hard copies
- All schedule II orders will be entered into CPRS like any other prescription
THEN....
- The physician must print and sign the order from CPRS and have the patient or agent bring down to the outpatient pharmacy (mailed from the CBOCs) in order for the prescription to be filled

Directions for Printing

1. In "ORDER" tab, highlight order
2. Go to "FILE"
3. Enter print
4. Enter your location
5. Check "order" and enter printer location
6. Print

Finishing and Filing in Pharmacy

- Schedule II orders that print (from 1070C), should be given to hot seat pharmacist
- Hot seat pharmacist must wait for the signed copy to finish and fill the order
- Keep the copy that is signed for filing
- Continue to file separate from all other orders

Conforms to VHA Handbook 1108.05 and 21 CFR 130(e).05.

Dr. Houlihan is the only one who is doing this right now. Heather had contact Spokane VA back in Sept to get their process and she came up with the above process to help make sure it is easy to follow. Dr. Houlihan wants all providers to go this route to prevent needs for re-writes due to omissions, unapproved abbreviations, etc. The next page shows the example of what the providers will be providing to us.

Attachment C

12/19/08 FRI 15:29 FAX 7865

MAIN PHARMACY

0001

MEDICAL RECORD | DOCTOR'S ORDERS
 NOTE: Physician's signature must accompany each entry including standing orders
 Date and time for instituting and discontinuing the orders must be recorded
 DATE & TIME | ORDERS | SIGNATURES

12/15/2008 08:54 dc Hold MORPHINE TAB,SA 30MG
 TAKE THREE TABLETS BY MOUTH THREE
 TIMES A DAY FOR PAIN
 Quantity: 270 Refills: 0
 <Requesting Physician Cancelled>
 Start: 12/15/2008

Days Supply:

res/ Dr. _____
 ↑
 Electronic sig & DEA# Attached
 (wet signature also required)

C

Example

PF NAME _____ PF SS# _____
 MEDICAL RECORD
 LDC: PHARMACY TRIAGE COEUR D'ALENE Date: 12/19/2008
 Room/Bed:
 Manual Reprint: 12/19/2008 14:03
 DOCTOR'S ORDERS
 VA FORM 10-1158
 VA form# _____

Attachment C

Prescriptions under Clarification

When a pharmacist receives a prescription that he/she needs to clarify what course of action should he/she pursue?

- Step 1** Fax or call provider with his/her concerns. If the patient is waiting for the prescription, the patient will be notified immediately that there is a question regarding his/her prescription and it may take time to get this issue address. Patient should be given the option to wait or have the prescription mailed, since he/she may be waiting a long time.
- Step 2** If the provider does not agree with the recommendation or chooses not to change the prescription, the pharmacist may decide to fill the prescription with a comment added to the providers note providing documentation of references and rational for concern for the order written. The pharmacist is to add the provider on as a co-signature.
Step 1 and 2 should be done within 48 hours.
- Step 3** Designated personal should follow up on orders faxed to providers. If order is not clarified after two faxes the pharmacist should make an attempt to contact provider by phone.
- Step 4A** If provider does not agree with the recommendation or chooses not to change the prescription, the pharmacist must consult with a minimum of three pharmacists to decide if a 3 day supply of medication should be filled for the patient while waiting for resolution of the prescription. If the 3 day supply is dispensed the prescription is now void. The provider will need to write new order if the remainder of the prescription is to be dispensed. If the majority consensus is to decline the 3 day supply the pharmacist will hand the prescription and the related correspondence to the pharmacy coordinator.
(In-patient pharmacy – Kari Johnson, Rph, Out-patient pharmacy – Erin Narus Pharm.D., Non-formulary – Rich Schroeder, Pharm.D.)
- Step 4B** The appropriate pharmacy coordinator will then review the order and the related data. He/she will then decide if the order is to be filled as written or if a second attempt to reach the provider and explain the situation is needed. The coordinator may choose to dispense a 3 day supply at that time.
- Step 5** Provider does not agree with our second recommendation or chooses not to change the prescription. If the pharmacy coordinator decides to fill the prescription a comment should be added to the providers note providing documentation of references and rational for concern for the order written. The pharmacy coordinator is to add the provider on as a co-signature.
- Step 6** Provider does not agree with the recommendation or chooses not to change the prescription. If the pharmacy coordinator decides not to fill the prescription, then he/she will hand the prescription and the related information to the pharmacy program manager – Tom Jaeger.
- Step 7** The pharmacy program manager will review all related information and make his/her decision.

Attachment G

Johnson, Noelle A.

From: Waldstein, Janice L.
Sent: Monday, March 30, 2009 11:27 AM
To: Johnson, Noelle A.
Subject: FW:

Here's the response.
 Have a great and happy day, Oh you appreciated one, you...

From: Jaeger, Thomas A.
Sent: Monday, March 30, 2009 11:24 AM
To: Waldstein, Janice L.
Subject: RE:

Hi Jan,

Thank you for the feedback. I agree that Noelle is an exceptional pharmacist. It is always nice to get this sort of feedback to assure her that her work is appreciated. Thanks

Thomas Jaeger, PharmD
 Pharmacy Program Manager
 Tomah VA Medical Center
 O (608) 372-3971 x61266
 F (608) 372-1178
Thomas.Jaeger@va.gov

From: Waldstein, Janice L.
Sent: Monday, March 30, 2009 10:58 AM
To: Jaeger, Thomas A.
Subject:

Mr. Jaeger
 I am in the Wausau CBOC transition where the office is closing tomorrow as an agency staffed unit to being staffed by VA employees early in April. My future plan is to stay on to help the VA transition for a time. I have enjoyed my time as a locum here serving the Veterans in Wausau and surrounding areas. It's been a pleasure. But should something change, I want to make sure that I comment on my past exchanges with Noelle Johnson, PharmD. She is an amazingly gifted Pharmacist, in which I am completely in awe. Over these past five months I have learned so much from her. She has been extremely valuable to me as a provider. She is always at the other end of the phone, willing to listen, and willing to help create a plan of care with me. Also, she has been very helpful in becoming an active member of the usual triad: the patient, Noelle and me with regards to improving pain management for many and now has helped me attempt improving patients with out of control diabetes and blood pressures. As a provider I try to always do due diligence in involving the VA Specialty departments for chart/lab/medication reviews. And this has been pretty helpful also. But consistently, it is Noelle that is always accessible, always willing and able to help me make knowledgeable, evidence-based plans of care for some really difficult patients.

I applaud her.
 Thank you,
 Jan

DEPARTMENT OF
VETERANS AFFAIRS

Memorandum

Date: June 16, 2009
From: Manager, Great Lakes Human Resources Management Division (GLHRMS)
Subj: Discharge During Probationary Period
To: Noelle Johnson

1. On September 14, 2008, you were given an excepted appointment to the full-time position of Staff Pharmacist, GS-12. At that time, you were advised that the first year of your appointment is set aside as a probationary period in order for a determination to be made regarding your suitability for continued employment. During this period, your supervisor may recommend your separation at any time if it is believed that you may not develop into a satisfactory employee.
2. Due to your performance issues, it has been determined that your services are no longer needed. Therefore, you will be separated from employment effective June 30, 2009.
3. If you do not understand the reason for this action, you are entitled to a further explanation. If you desire such an explanation, you should request a meeting with your supervisor as soon as possible for an informal discussion of the matter.
4. You may appeal this action to the Merit Systems Protection Board if you feel that it was based solely upon consideration of lawful partisan political affiliation or your marital status. You may also appeal this action to the Merit Systems Protection Board if you feel it was based on discrimination because of race, color, religion, sex (including sexual harassment), national origin, age (40 and over), reprisal for involvement in a prior discrimination complaint, or physical handicap if such discrimination is raised in addition to either lawful partisan political affiliation or marital status as bases for this action. Your appeal must be in writing and submitted to the Regional Administrator, Merit Systems Protection Board, Great Lakes Region, 230 S. Dearborn St., 31st Floor, Chicago, IL 60604. An appeal may be filed at any time after the effective date of the action that is being appealed, but not later than 30 calendar days after the effective date of this action.
5. You have the right to appeal this action under the Department of Veterans Affairs' discrimination complaint procedure if you feel that it is based solely on discrimination because of race, color, religion, sex (including sexual harassment), age (40 and over), national origin, handicap, or reprisal because of involvement in a prior complaint. To utilize the

Attachment N1

discrimination complaint procedure, you must first consult with an EEO Counselor at the Office of Resolution Management (ORM) at 1-888-737-3361, not later than 45 calendar days after the effective date of this action.

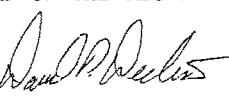
6. You may exercise your right to appeal to either the Merit Systems Protection Board or the Department of Veterans Affairs' discrimination complaints procedure, but you may not appeal to both. You will be deemed to have exercised your choice of appeal procedure if and when you file a timely appeal as described in paragraph 4 or 5 above.

7. If you have any questions about this action or your appeal rights, you may contact the Human Resources office of this Medical Center.

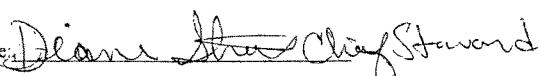
8. Please contact Great Lakes Human Resources Management Service, extension 61638 to schedule an exit interview. At that time you will be told how to arrange for clearance from the Medical Center and how to obtain benefits due to you.


WAYNE H. DAVIS

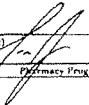
I CERTIFY THAT I HAVE RECEIVED THE ORIGINAL OF THE ABOVE
MEMORANDUM DATED JUNE 16, 2009:

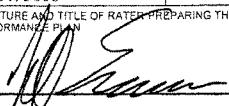
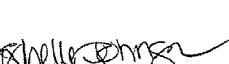
Refused to sign Jun 16, 09 
NOELLE JOHNSON DATE

I have been offered union representation: (initial) _____ (initial)
Accepted Declined

Union Representative signature: 

REPORT OF CONTACT NOTE: This form must be filled out in or on typewriter as it becomes a permanent record in veterans' folders.		VA OFFICE VA Medical Center Tomah WI 54660	IDENTIFICATION NOS. (C,X,CSS,XSS,V,K, etc.)
LAST NAME-FIRST NAME-MIDDLE NAME OF STAFF (Type or print) N. Johnson Pharm.D.		DATE OF CONTACT 5-27-09	
ADDRESS OF VETERAN		TELEPHONE NO. OF VETERAN	
PERSON CONTACTED M. Hyde		TYPE OF CONTACT (Check) <input checked="" type="checkbox"/> PERSONAL <input type="checkbox"/> TELEPHONE	
ADDRESS OF PERSON CONTACTED		TELEPHONE NO. OF PERSON CONTACTED	
BRIEF STATEMENT OF INFORMATION REQUESTED AND GIVEN [Background: On approximately 5-15-09 Johnson handed over the leadership of the opioid work group and membership on the various pain committees to Hyde. She also stated that she would no longer handle consults on pain patients, "appointing" Hyde as the person to handle such consults, and handing over the patients with whom she was dealing.] On 5-27-09, Johnson called the library conference room, during the Infection Control Committee meeting, to question Hyde on the approval of an oxycodone dose increase for a pain patient. Hyde had already discussed this with the provider, (patient had increased dose himself; so we were continuing current dose). There was a plan in place to bring patient to the hospital of observed adjustment of pain medication on 6-1-09. Hyde had also talked to the dispensing pharmacist and discussed the plan. This pharmacist agreed to fill the Rx.			
DIVISION OR SECTION	EXECUTED BY (Signature and Title)		

JUN-16-2009 16:00		TOMAH-KUAMC-CHAPLA/JNJB		4688 372 1178	P.01/01
<small>NOTE: This form must be filled out in ink or on typewriter as it becomes a permanent record in veterans' folders.</small>		<small>VA Medical Center Tomah WI 54660</small>			
LAST NAME-FIRST NAME-MIDDLE NAME OF VETERAN (Type or print)				DATE OF CONTACT 1/5/09-6/1/09	
Johnson, Noelle					
ADDRESS OF VETERAN				TELEPHONE NO. OF VETERAN	
PERSON CONTACTED				TYPE OF CONTACT (Check)	
				<input checked="" type="checkbox"/> PERSONAL <input type="checkbox"/> TELEPHONE	
ADDRESS OF PERSON CONTACTED				TELEPHONE NO. OF PERSON CONTACTED	
BRIEF STATEMENT OF INFORMATION REQUESTED AND GIVEN					
<p>Over the past few months there have been several instances where Noelle has created tense environments between pharmacy staff members. She has a tendency to pull team members apart. The latest instance was when she refused to work the 9-5:30 shift. She claimed that the least senior person needs to work that shift. This alienated the other pharmacists by creating a rift of who's side should they support. In the end, another pharmacist decided to end the battle by offering to pick up her shifts. This resolved the situation, but left a bitter taste in everyone's mouth about her selfishness.</p> <p>Another instance is when a prescription came through the pharmacy department and after it was filled, she questioned the pharmacist on why they did that. The response was because it is a refill for the past 5 years. Her demeanor was that everyone else must be stupid that they don't know what she knows. She reversed the prescription and sent it to the PharmD's to seek clarification. This situation created controversy between the pharmacists and also providers.</p> <p>The pharmacy department needs to act as a team that is willing to work together. I do not feel that Noelle has the capability to function in this capacity. She uses her tenacity to enforce her opinion on others. Several pharmacists have tried to coach her on how to interact, but all have given up. In fact Noelle has turned on them and now insults them behind their backs in front of others. She does not fit into the culture of this facility or pharmacy department.</p>					
DIVISION OR SECTION Support Services Pharmacy Department		EXECUTED BY (Signature and Title)		 Thomas A. Jaeger, Pharm.D., RPh Pharmacy Program Manager	

VA Department of Veterans Affairs		PERFORMANCE APPRAISAL PROGRAM		
IMPORTANT: For additional information see VA Handbook 5013/1, Part 1. If additional space is needed for any item on this form, use page 5.				
PERFORMANCE PLAN AND APPRAISAL OF				
EMPLOYEE'S NAME (Last, First, Middle Initial)	POSITION TITLE, SERIES AND NUMBER		GRADE/SALARY	
Johnson, Noelle A.	Clinical Staff Pharmacist		GS-11	
DEPARTMENT/OFFICE			LOCATION	
Support Service Line/Pharmacy		Tomah, WI 54660		
DATE ASSIGNED PRESENT POSITION	DUE DATE OF WITHIN-GRADE INCREASE	PERIOD COVERED BY THIS PERFORMANCE PLAN		
08/04/2008		FROM 08/04/2008	TO 11/04/2008	
SIGNATURE AND TITLE OF RATER PREPARING THIS PERFORMANCE PLAN	DATE	SIGNATURE OF EMPLOYEE	DATE	
	8/4/08		8/4/08	
SECTION A - PERFORMANCE PLAN				
<p>Reflect the performance elements for the position to be rated. An element is defined as a component of a position that is sufficiently important to warrant written appraisal. Normally each position has four or five elements. Designate with an asterisk the element(s) considered critical. Specific performance standards must be written for each element. There are usually three to five performance standards for each element. When writing performance standards, only the fully successful level of achievement need be defined.</p>				
<p>PERFORMANCE ELEMENTS/STANDARDS</p> <p>PERFORMANCE STANDARDS</p> <p>CLINICAL PHARMACIST</p> <p>A. CLINICAL FUNCTIONS *</p> <ol style="list-style-type: none"> Provides recommendations and input relative to cost-effective drug therapy Serves as the drug information and pharmacotherapeutics specialist - evaluates patients & makes appropriate recommendations on drug therapy, solves therapeutic dilemmas and interacts on patient/physician rounds/meetings <p>B. PROGRAM MANAGEMENT</p> <ol style="list-style-type: none"> Coordinates adverse drug reaction programs for Pharmacy Service Provides drug evaluations to medical center & VISN P&T Committee regarding drug requests Provides documentation of interventions with staff and providers for Pharmacy Service monitoring programs <p>C. COMMUNICATIONS</p> <ol style="list-style-type: none"> Communicates effectively and courteously in a professional manner with all patients and VA employees Cooperates fully & provides technical assistance to nursing & medical staff At least one cost-saving or timesaving idea will be implemented during the rating 				

VA FORM NOV 2003 (RS) 0750

AdobeFormsDesigner

Attachment N4

SECTION A - PERFORMANCE PLAN (Continued)	
PERFORMANCE ELEMENTS/STANDARDS	
D. VALUE ADDED SERVICE & CUSTOMER SERVICE *	
<p>1. Cooperation - After completing own duties, employee demonstrates cooperation by recognizing the needs of the service and taking the opportunity to assist co-workers with their assignments. Communicates openly with co-workers and supervisors to ensure a smooth running operation</p> <p>2. Productivity - Functions with minimal or no supervision. Utilizes spare time in a manner constructive to the medical center.</p> <p>3. Personal contacts - Maintains a professional manner that is polite, responsive, and considerate when dealing with patients or staff. Accepts constructive criticism in a positive manner. Supportive of changes in policies or procedures, and appropriately questions methods and procedures when problems arise, while providing constructive feedback</p>	
E. CORE COMPETENCIES FOR ALL EMPLOYEES	
<p>1. Utilities and equipment maintenance: - Demonstrates ability to operate and maintain equipment & utilities specific to their duties</p> <p>2. Security:</p> <p>a. Demonstrates knowledge of their role in the security of patients, visitors, and staff.</p> <p>b. Demonstrates knowledge of their role in the protection of personal and government property, including appropriate security of all computer systems.</p> <p>3. Age specific:</p> <p>a. Demonstrates understanding of the developmental stages of life, including adult stage (18-64) and geriatric stage (65 or older)</p> <p>b. Demonstrates understanding of the modifications of drug therapy and dosing in the geriatric patient</p>	
<p>4. Violence in the Workplace:</p> <p>a. Identifies factors that contribute to violent behavior</p> <p>b. Recognizes behaviors that indicate a potential for violence (anger, increased physical activity, verbal clues, body language)</p> <p>5. General Safety:</p> <p>a. Demonstrates knowledge of their roles & responsibilities in occupational safety & health, fire protection, and emergency preparedness</p> <p>b. Recognizes safety hazards and takes action to correct them.</p> <p>c. Practices safe work habits. Two exceptions per 180 days.</p> <p>6. Infection Control: Demonstrates knowledge of their role relating to the prevention and control of infection</p> <p>5-Level Performance Standards: Information Security and Confidentiality</p> <p>(SEE FINAL PAGE)</p>	

SECTION A - PERFORMANCE PLAN *(Continued)*

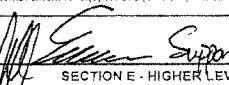
PERFORMANCE ELEMENTS/STANDARDS

CHANGES TO PERFORMANCE PLAN <i>(Changes may be recorded anytime during the rating period)</i>			
ELEMENT DESCRIPTION/TITLE			
STANDARD (S)			
ELEMENT DESCRIPTION/TITLE			
STANDARD (S)			
SIGNATURE OF RATER	DATE	SIGNATURE OF EMPLOYEE	DATE
SECTION B - PROGRESS REVIEW			
At least one progress review is required during the appraisal year. Employee must be informed of his/her progress as measured against the performance plan. Additional progress reviews may be documented on page 6.			
A performance review was conducted and discussed, and the employee's performance as of this date:			
<input type="checkbox"/> Is considered Fully Successful or better. <input type="checkbox"/> Needs improvement to be Fully Successful or better. <i>(See VA Handbook, 5013.1, Part 1, Paragraph 7, for additional required action.)</i>			
SIGNATURE OF RATER	DATE	SIGNATURE OF EMPLOYEE	DATE

SECTION C - ACTUAL ACHIEVEMENT			
Indicate the single, overall level of achievement that best describes the employee's performance for each ELEMENT shown in Section A. Do not indicate achievement for each individual standard. Specific examples of performance must be provided in the space below for each element where a level of achievement other than Fully Successful has been assigned. Assignment of the Exceptional level means that Fully Successful performance standards have been significantly surpassed. This level is reserved for employees whose performance in the element far exceeds normal expectations and results in major contributions to the accomplishment of organizational goals.			
ELEMENTS <i>(Use the same key word description for each element as in Section A)</i>	LEVELS OF ACHIEVEMENT		
	EXCEPTIONAL	FULLY SUCCESSFUL	LESS THAN FULLY SUCCESSFUL
CLINICAL FUNCTIONS *	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
PROGRAM MANAGEMENT	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
CUSTOMER SERVICE & VALUE-ADDED SERVICE *	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
COMMUNICATIONS	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
CORE COMPETENCIES	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe specific examples of performance for each element where a level of achievement other than Fully Successful has been assigned above. Specific achievements at the Fully Successful level may be described.

ELEMENT(S)/ACHIEVEMENT(S)

<p>NARRATIVE SUMMARY - OPTIONAL (Provide any additional significant accomplishments, as well as other factors such as details or training experiences related to the overall performance plan. Capacity to assume a more responsible position may also be addressed.)</p>								
SECTION D - OVERALL RATING								
<table border="0"> <tr> <td colspan="2">TYPE OF RATING</td> <td>SUMMARY RATING (POSITION CHANGES - EMPLOYEE OR RATER)</td> </tr> <tr> <td><input checked="" type="checkbox"/> ANNUAL RATING OF RECORD</td> <td><input type="checkbox"/> SPECIAL RATING OF RECORD</td> <td></td> </tr> </table>			TYPE OF RATING		SUMMARY RATING (POSITION CHANGES - EMPLOYEE OR RATER)	<input checked="" type="checkbox"/> ANNUAL RATING OF RECORD	<input type="checkbox"/> SPECIAL RATING OF RECORD	
TYPE OF RATING		SUMMARY RATING (POSITION CHANGES - EMPLOYEE OR RATER)						
<input checked="" type="checkbox"/> ANNUAL RATING OF RECORD	<input type="checkbox"/> SPECIAL RATING OF RECORD							
<p>PERIOD COVERED BY THIS APPRAISAL</p> <table border="0"> <tr> <td>FROM 08/04/2008</td> <td>TO 11/04/2008</td> </tr> </table>			FROM 08/04/2008	TO 11/04/2008				
FROM 08/04/2008	TO 11/04/2008							
<p>NOTE: Recommended Performance Rating - Using achievement levels assigned in Section C and the criteria described below, check the appropriate rating.</p>								
<p>PERFORMANCE RATING</p> <table border="0"> <tr> <td><input type="checkbox"/> OUTSTANDING - Achievement levels for all elements are designated as Exceptional</td> </tr> <tr> <td><input type="checkbox"/> EXCELLENT - Achievement levels for all critical elements are designated as Exceptional. Achievement levels for noncritical elements are designated as at least Fully Successful. Some, but not all, noncritical elements may be designated as Exceptional.</td> </tr> <tr> <td><input checked="" type="checkbox"/> FULLY SUCCESSFUL - The achievement level for at least one critical element is designated as Fully Successful. Achievement levels for other critical and noncritical elements are designated as at least Fully Successful or higher.</td> </tr> <tr> <td><input type="checkbox"/> MINIMALLY SATISFACTORY - Achievement levels for all critical elements are designated as at least Fully Successful. However, the achievement level(s) for one (or more) noncritical elements is (are) designated as Less Than Fully Successful.</td> </tr> <tr> <td><input type="checkbox"/> UNSATISFACTORY - The achievement level(s) for one (or more) critical element(s) is (are) designated as Less Than Fully Successful.</td> </tr> </table>			<input type="checkbox"/> OUTSTANDING - Achievement levels for all elements are designated as Exceptional	<input type="checkbox"/> EXCELLENT - Achievement levels for all critical elements are designated as Exceptional. Achievement levels for noncritical elements are designated as at least Fully Successful. Some, but not all, noncritical elements may be designated as Exceptional.	<input checked="" type="checkbox"/> FULLY SUCCESSFUL - The achievement level for at least one critical element is designated as Fully Successful. Achievement levels for other critical and noncritical elements are designated as at least Fully Successful or higher.	<input type="checkbox"/> MINIMALLY SATISFACTORY - Achievement levels for all critical elements are designated as at least Fully Successful. However, the achievement level(s) for one (or more) noncritical elements is (are) designated as Less Than Fully Successful.	<input type="checkbox"/> UNSATISFACTORY - The achievement level(s) for one (or more) critical element(s) is (are) designated as Less Than Fully Successful.	
<input type="checkbox"/> OUTSTANDING - Achievement levels for all elements are designated as Exceptional								
<input type="checkbox"/> EXCELLENT - Achievement levels for all critical elements are designated as Exceptional. Achievement levels for noncritical elements are designated as at least Fully Successful. Some, but not all, noncritical elements may be designated as Exceptional.								
<input checked="" type="checkbox"/> FULLY SUCCESSFUL - The achievement level for at least one critical element is designated as Fully Successful. Achievement levels for other critical and noncritical elements are designated as at least Fully Successful or higher.								
<input type="checkbox"/> MINIMALLY SATISFACTORY - Achievement levels for all critical elements are designated as at least Fully Successful. However, the achievement level(s) for one (or more) noncritical elements is (are) designated as Less Than Fully Successful.								
<input type="checkbox"/> UNSATISFACTORY - The achievement level(s) for one (or more) critical element(s) is (are) designated as Less Than Fully Successful.								
<p>SIGNATURE AND TITLE OF RATER  Support Service Line Manager DATE 11/26/08</p>								
<p>SECTION E - HIGHER LEVEL REVIEW/APPROVAL</p> <p>Required only for Minimally Satisfactory and Unsatisfactory ratings of record; unless organization has chosen to have higher level approval required for Outstanding ratings of record.</p> <table border="0"> <tr> <td><input type="checkbox"/> Concur with recommended rating.</td> </tr> <tr> <td><input type="checkbox"/> Do not concur with rating. Approve rating of _____</td> </tr> </table>			<input type="checkbox"/> Concur with recommended rating.	<input type="checkbox"/> Do not concur with rating. Approve rating of _____				
<input type="checkbox"/> Concur with recommended rating.								
<input type="checkbox"/> Do not concur with rating. Approve rating of _____								
<p>BASIS FOR PERFORMANCE RATING CHANGE</p>								
<p>SIGNATURE AND TITLE OF APPROVAL OFFICIAL DATE</p>								
<p>A copy of this performance appraisal was given to me. ► SIGNATURE OF EMPLOYEE DATE 11/26/08</p>								

<p>USE THIS AREA FOR ANY ADDITIONAL INFORMATION</p> <p>5-Level Performance Standards: Information Security and Confidentiality</p> <p>A. Computer System Security</p> <p>Effectively safeguards all assigned computer system passwords and codes (access/verify codes, electronic signature codes, etc.) Consistently abides by established policies prohibiting the download of patient-specific data from the VA computer system to portable storage media such as diskettes, compact discs, zip discs, etc.; policies prohibiting employees from carrying any portable computer equipment or storage media containing any patient-specific data off VA premises; and policies prohibiting the loading of personal, non-VHA software to any VHA computing equipment. No instances of deliberate violation of established computer security policies are allowed during the rating period.</p> <p>B. Confidentiality of Information</p> <p>Consistently limits personal access to all sensitive information and records, including patient medical records, other patient-specific information, personnel records, and employee health medical records, to those instances in which there is a specific job-related purpose. Consistently maintains confidentiality of all sensitive patient and employee records and information, and limits disclosure of such information to only those individuals who have a specific job-related need to know the information. Utilizes software encryption as required on any laptop or personal computer as directed by VA IT Operations and Management. No instances of deliberate unauthorized access or disclosure of sensitive information are allowed during the rating period.</p>

VA Department of Veterans Affairs		PERFORMANCE APPRAISAL PROGRAM		
<i>IMPORTANT: For additional information see VA Handbook 5013/I, Part 1. If additional space is needed for any item on this form, use page 6.</i>				
PERFORMANCE PLAN AND APPRAISAL OF				
EMPLOYEE'S NAME (Last, First, Middle Initial) Johnson, Noelle A.		POSITION TITLE, SERIES AND NUMBER Clinical Staff Pharmacist		GRADE/SALARY GS-12
DEPARTMENT/OFFICE Support Service Line/Pharmacy			LOCATION Tomah, WI. 54660	
DATE ASSIGNED PRESENT POSITION 08/04/2008		DUE DATE OF WITHIN-GRADE INCREASE 11/5/08	PERIOD COVERED BY THIS PERFORMANCE PLAN FROM 08/04/2008 TO 11/04/2008	
SIGNATURE AND TITLE OF RATER PREPARING THIS PERFORMANCE PLAN <i>Deean Robinson for Jeff Evanson</i>		DATE 10-28-08	SIGNATURE OF EMPLOYEE <i>Noelle Johnson</i>	DATE 10/28/08
SECTION A - PERFORMANCE PLAN				
Reflect the performance elements for the position to be rated. An element is defined as a component of a position that is sufficiently important to warrant written appraisal. Normally each position has four or five elements. Designate with an asterisk the element(s) considered critical. Specific performance standards must be written for each element. There are usually three to five performance standards for each element. When writing performance standards, only the fully successful level of achievement need be defined.				
PERFORMANCE ELEMENTS/STANDARDS				
<p>PERFORMANCE STANDARDS CLINICAL PHARMACIST</p> <p>A. CLINICAL FUNCTIONS *</p> <ol style="list-style-type: none"> Provides recommendations and input relative to cost-effective drug therapy Serves as the drug information and pharmacotherapeutics specialist - evaluates patients & makes appropriate recommendations on drug therapy, solves therapeutic dilemmas and interacts on patient/physician rounds/meetings <p>B. PROGRAM MANAGEMENT</p> <ol style="list-style-type: none"> Coordinates adverse drug reaction programs for Pharmacy Service Provides drug evaluations to medical center & VISN P&T Committee regarding drug requests Provides documentation of interventions with staff and providers for Pharmacy Service monitoring programs <p>C. COMMUNICATIONS</p> <ol style="list-style-type: none"> Communicates effectively and courteously in a professional manner with all patients and VA employees Cooperates fully & provides technical assistance to nursing & medical staff At least one cost-saving or timesaving idea will be implemented during the rating 				

VA FORM NOV 2003 (RS) **0750**

AdobeFormsDesigner

Attachment N4

SECTION A - PERFORMANCE PLAN (Continued)	
PERFORMANCE ELEMENTS/STANDARDS	
<p>D. VALUE ADDED SERVICE & CUSTOMER SERVICE *</p> <p>1. Cooperation - After completing own duties, employee demonstrates cooperation by recognizing the needs of the service and taking the opportunity to assist co-workers with their assignments. Communicates openly with co-workers and supervisors to ensure a smooth running operation</p> <p>2. Productivity - Functions with minimal or no supervision. Utilizes spare time in a manner constructive to the medical center.</p> <p>3. Personal contacts - Maintains a professional manner that is polite, responsive, and considerate when dealing with patients or staff. Accepts constructive criticism in a positive manner. Supportive of changes in policies or procedures, and appropriately questions methods and procedures when problems arise, while providing constructive feedback</p>	
<p>E. CORE COMPETENCIES FOR ALL EMPLOYEES</p> <p>1. Utilities and equipment maintenance: - Demonstrates ability to operate and maintain equipment & utilities specific to their duties</p> <p>2. Security:</p> <ul style="list-style-type: none"> a. Demonstrates knowledge of their role in the security of patients, visitors, and staff. b. Demonstrates knowledge of their role in the protection of personal and government property, including appropriate security of all computer systems. <p>3. Age specific:</p> <ul style="list-style-type: none"> a. Demonstrates understanding of the developmental stages of life, including adult stage (18-64) and geriatric stage (65 or older) b. Demonstrates understanding of the modifications of drug therapy and dosing in the geriatric patient <p>4. Violence in the Workplace:</p> <ul style="list-style-type: none"> a. Identifies factors that contribute to violent behavior b. Recognizes behaviors that indicate a potential for violence (anger, increased physical activity, verbal clues, body language) <p>5. General Safety:</p> <ul style="list-style-type: none"> a. Demonstrates knowledge of their roles & responsibilities in occupational safety & health, fire protection, and emergency preparedness b. Recognizes safety hazards and takes action to correct them. c. Practices safe work habits. Two exceptions per 180 days. <p>6. Infection Control: Demonstrates knowledge of their role relating to the prevention and control of infection</p> <p>9-Level Performance Standards: Information Security and Confidentiality (SEE FINAL PAGE)</p>	

SECTION A - PERFORMANCE PLAN *(Continued)*

PERFORMANCE ELEMENTS/STANDARDS

CHANGES TO PERFORMANCE PLAN *(Changes may be recorded anytime during the rating period)*

ELEMENT DESCRIPTION/TITLE

STANDARD (S)

ELEMENT DESCRIPTION/TITLE

STANDARD (S)

SIGNATURE OF RATER	DATE	SIGNATURE OF EMPLOYEE	DATE
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SECTION B - PROGRESS REVIEW

At least one progress review is required during the appraisal year. Employee must be informed of his/her progress as measured against the performance plan. Additional progress reviews may be documented on page 6.

A performance review was conducted and discussed, and the employee's performance as of this date:

Is considered Fully Successful or better.

Needs improvement to be Fully Successful or better. *(See VA Handbook, 5013.1, Part I, Paragraph 7, for additional required action.)*

SIGNATURE OF RATER	DATE	SIGNATURE OF EMPLOYEE	DATE
--------------------	------	-----------------------	------

SECTION C - ACTUAL ACHIEVEMENT			
Indicate the single, overall level of achievement that best describes the employee's performance for each ELEMENT shown in Section A. Do not indicate achievement for each individual standard. Specific examples of performance must be provided in the space below for each element where a level of achievement other than Fully Successful has been assigned. Assignment of the Exceptional level means that Fully Successful performance standards have been significantly surpassed. This level is reserved for employees whose performance in the element far exceeds normal expectations and results in major contributions to the accomplishment of organizational goals.			
ELEMENTS <i>(Use the same key word description for each element as in Section A)</i>	LEVELS OF ACHIEVEMENT		
	EXCEPTIONAL	FULLY SUCCESSFUL	LESS THAN FULLY SUCCESSFUL
CLINICAL FUNCTIONS *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PROGRAM MANAGEMENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CUSTOMER SERVICE & VALUE-ADDED SERVICE *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COMMUNICATIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CORE COMPETENCIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe specific examples of performance for each element where a level of achievement other than Fully Successful has been assigned above.
Specific achievements at the Fully Successful level may be described.

ELEMENTS/ACHIEVEMENT(S)

<p style="text-align: center;">SECTION D - OVERALL RATING</p> <p>TYPE OF RATING</p> <p><input type="checkbox"/> ANNUAL RATING OF RECORD <input type="checkbox"/> SPECIAL RATING OF RECORD <input type="checkbox"/> SUMMARY RATING (POSITION CHANGES - EMPLOYEE OR RATER)</p> <p>PERIOD COVERED BY THIS APPRAISAL</p> <p>FROM 11/05/2008 TO 09/30/2009</p> <p>NOTE: Recommended Performance Rating - Using achievement levels assigned in Section C and the criteria described below, check the appropriate rating.</p> <p>PERFORMANCE RATING</p> <p><input type="checkbox"/> OUTSTANDING - Achievement levels for all elements are designated as Exceptional.</p> <p><input type="checkbox"/> EXCELLENT - Achievement levels for all critical elements are designated as Exceptional. Achievement levels for noncritical elements are designated as at least Fully Successful. Some, but not all, noncritical elements may be designated as Exceptional.</p> <p><input type="checkbox"/> FULLY SUCCESSFUL - The achievement level for at least one critical element is designated as Fully Successful. Achievement levels for other critical and noncritical elements are designated as at least Fully Successful or higher.</p> <p><input type="checkbox"/> MINIMALLY SATISFACTORY - Achievement levels for all critical elements are designated as at least Fully Successful. However, the achievement level(s) for one (or more) noncritical elements is (are) designated as Less Than Fully Successful.</p> <p><input type="checkbox"/> UNSATISFACTORY - The achievement level(s) for one (or more) critical element(s) is (are) designated as Less Than Fully Successful.</p>		
SIGNATURE AND TITLE OF RATER		DATE
<p style="text-align: center;">SECTION E - HIGHER LEVEL REVIEW/APPROVAL</p> <p>Required only for Minimally Satisfactory and Unsatisfactory ratings of record; unless organization has chosen to have higher level approval required for Outstanding ratings of record.</p> <p><input type="checkbox"/> Concur with recommended rating.</p> <p><input type="checkbox"/> Do not concur with rating. Approve rating of _____</p> <p>BASIS FOR PERFORMANCE RATING CHANGE</p>		
SIGNATURE AND TITLE OF APPROVAL OFFICIAL		DATE
A copy of this performance appraisal was given to me. ►		SIGNATURE OF EMPLOYEE DATE

USE THIS AREA FOR ANY ADDITIONAL INFORMATION
<p>5-Level Performance Standards: Information Security and Confidentiality</p> <p>A. Computer System Security</p> <p>Effectively safeguards all assigned computer system passwords and codes (access/verify codes, electronic signature codes, etc.) Consistently abides by established policies prohibiting the download of patient-specific data from the VA computer system to portable storage media such as diskettes, compact discs, zip discs, etc.; policies prohibiting employees from carrying any portable computer equipment or storage media containing any patient-specific data off VA premises; and policies prohibiting the loading of personal, non-VHA software to any VHA computing equipment. No instances of deliberate violation of established computer security policies are allowed during the rating period.</p> <p>B. Confidentiality of Information</p> <p>Consistently limits personal access to all sensitive information and records, including patient medical records, other patient-specific information, personnel records, and employee health medical records, to those instances in which there is a specific job-related purpose. Consistently maintains confidentiality of all sensitive patient and employee records and information, and limits disclosure of such information to only those individuals who have a specific job-related need to know the information. Utilizes software encryption as required on any laptop or personal computer as directed by VA IT Operations and Management. No instances of deliberate unauthorized access or disclosure of sensitive information are allowed during the rating period.</p>

To whom it may concern:

On Wednesday June 17, 2009, Dr. Houlihan called a meeting with Heather Ashmus, Pharm.D. and Rebecca Bell, Pharm.D. at 3pm. The intended purpose of this meeting was to discuss opportunities for growth in the pharmacy department. However, during this meeting Dr. Houlihan referenced a recently terminated employee, Noelle Johnson Pharm.D., numerous times as an example of the way not to approach him with any questions regarding his prescribing. He reported that she had thrown papers in his face, that she had called him incompetent, and accused her of not fully reading patient charts in full prior to calling him with recommendations. He also stated that, "Noelle is book smart but not clinically mature." The day following the meeting both Heather and Rebecca were approached by Margaret Hyde Pharm.D. and were told that the discussion of Noelle was not the intention that Dr. Houlihan had in mind for the meeting but to encourage each person's growth within the department. Indicating that Dr. Houlihan was aware that he should not have discussed these incidents with the two employees.

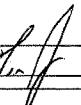
Heather Ashmus Pharm.D.



Rebecca Bell Pharm.D.



Attachment Q

REPORT OF CONTACT		VA OFFICE	IDENTIFICATION NOS. (C,X,C,SS,XSS,V,K, etc.)
NOTE: This form must be filled out in or on typewriter as it becomes a permanent record in veterans' folders.		VA Medical Center Tomah WI 54660	
LAST NAME-FIRST NAME-MIDDLE NAME OF VETERAN (Type or print)		DATE OF CONTACT	
Noelle Johnson		6/18/09	
ADDRESS OF VETERAN		TELEPHONE NO. OF VETERAN	
PERSON CONTACTED		TYPE OF CONTACT (Check)	
		<input checked="" type="checkbox"/> PERSONAL <input type="checkbox"/> TELEPHONE	
ADDRESS OF PERSON CONTACTED		TELEPHONE NO. OF PERSON CONTACTED	
BRIEF STATEMENT OF INFORMATION REQUESTED AND GIVEN			
<p>Noelle called my personal cell phone on 6/18/09 at approximately 0945. I did not answer the phone. I checked the voicemail that she left. The voice mail stated:</p> <p>"Will you be willing to write a retraction to your statement, this will determine the direction my lawyer will proceed"</p> <p>I did not respond to her call.</p> <p>I am <u>not</u> willing to write a retraction to my statement from the report of contact on 6/12/09. I stand by my decision that she has unsatisfactory performance in regards to interpersonal effectiveness. This can be seen in multiple charts by her refusing to fill prescriptions after clarification with the providers. She is incapable of respecting others decisions, which has created an intimidating and hostile work environment. Therefore, I believe the rating of unsatisfactory during her probationary period is the proper decision.</p>			
DIVISION OR SECTION		EXECUTED BY (Signature and Title)	
Support Service		 Thomas A. Jagger, Pharm.D., RPh	

6/18/09

To Whom It May Concern:

My name is Laureen R. Chambers, PharmD. As a practicing pharmacist since 1999 and an officer in the military, I have had the opportunity to be a colleague of Noelle Johnson, PharmD for the past year at the Tomah VA Medical Center. During this time, we have worked in a specialty pharmacy clinic caring for anticoagulation, lipid, new patient medication orientation, drug information questions, non-formulary medication requests and other duties as assigned. This clinic is in one room with three adjacent workstations. With three telephone lines and an open door policy, each pharmacist must be willing to step up and handle a multitude of problems everyday. Our workload can be extremely intense and erratic with multiple telephones ringing and patients stopping in without appointments and needing immediate assistance. We have to work as a team and know what the other people are doing in the room to make sure the veterans and providers are helped.

That being said, I have only seen Noelle perform her duties with the utmost respect and concern for our veterans. She has been willing to answer phone calls, see extra patients or cover clinic if one of the other pharmacists are gone. Noelle has been an excellent team player. Veterans will suffer with her not being in clinic.

Noelle has earned the respect and confidence of providers. Many would specifically ask for Noelle to help them with their difficult pain and diabetic patients. She has excellent medical skills and extreme patience with these needy and often non-compliant patients. I have witness Noelle, win over the confidence of a brittle diabetic patient that would not follow his primary care providers recommendation. When his provider did not have the time to get this patient to adjust his insulin appropriately, Noelle continued to explain and work with the patient to get him to follow his providers recommendations. She continued to regularly follow up with this veteran, who now trusts her completely. The provider is also thankful and pleased with the outcome. Noelle has more experience working in a pain clinic and with a certified pain specialist than any other pharmacist at the Tomah VA. I would always defer pain medication questions to her for her expert advice. She has worked with several primary care providers at Tomah and our CBOC to lessen their pain and improve their quality of life. Her being pulled from the pain committee and working with veterans in pain has created a void that has not been filled.

patient

Noelle is a team player and was working on reorganizing our lipid clinic and taking on the monitoring of our patients on erythropoietin stimulating agents. She is a unique pharmacist highly skilled in her profession, motivated to make the extra effort to help our providers and veterans and truly a vibrant and fun loving individual.


Laureen R. Chambers, PharmD

Captain, Minnesota Air National Guard

Veteran OIF/OEF

To whom it may concern:

I spent the past year working with Noelle Johnson, Pharm.D. at the Tomah VA. She provided a great wealth of knowledge to me as a first year pharmacist, especially with diabetes and pain. She was always willing to help and guide me to grow as a provider. Noelle has a passion for pharmacy and her patients. She always strived to provide her patients with a safe and efficacious regimen and was proud to let people know this was her ultimate goal. She has an outgoing personality that helped make and maintain great relationships with fellow pharmacists and providers. She will be missed by many at the VA. Her absence has left a hole that will be hard to fill on a professional and personal level.

Heather Ashmus Pharm.D.

Handwritten signature of Heather Ashmus, Pharm.D.

Attachment T3

06/09

TO WHOM IT MAY CONCERN:

THIS IS TO CERTIFY THAT
I, ROGER E. MAYERSON, A
CONTRACT PHARMACIST EMPLOYEE
AT THE TOMAH V. A. HOSPITAL
PHARMACY, DO HEREBY PROFOUNDLY
OBJEST TO NOELLE
TERMINATION AS A CLINICAL
PHARMACIST. THIS PHARMACIST
CONDUCTED HERSELF IN A
PROFESSIONAL DEMEANOR
AT ALL TIMES AND WAS AN
INTEGRAL PART OF OUR
PHARMACEUTICAL TEAM. NEVER
AT ANY TIME DID SHE
ANTAGONIZE ANY OF HER PEERS.
HER DISMISSAL IS AN INSULT
AND AN IMPAIRMENT ON THE
MEDICAL PROFESSION

ROGER E. MAYERSON

Roger E. Mayerson

once daily
Avandaryl™
 rosiglitazone maleate
 and glimepiride

Avandamet®
 rosiglitazone maleate/metformin HCl

Avandia
 rosiglitazone maleate

Please see accompanying complete Prescribing Information for Avandamet, including boxed WARNING
 for lactic acidosis and contraindications for patients with renal disease.

 GlaxoSmithKline

Avandia and Avandamet are registered trademarks and Avandaryl is a trademark
 of the GlaxoSmithKline group of companies.
 ©2006 The GlaxoSmithKline Group of Companies. All rights reserved. AY49391 February 2006

9816 Elan Road
Tomah Wisconsin, 54660
608-387-2628

June 17, 2009

To Whom It May Concern,

I have worked for the VA as a pharmacist for over 30 years, retiring in June 2006 and am now employed by the Tomah VA on a contract basis.

I have known and worked with Noelle Johnson since she came to the Tomah VA in the summer of 2008. I have found her to be a very knowledgeable pharmacist. Professionally, she works hard, is conscientious, and is concerned about proper use of medication and regards patient safety of utmost importance.

In professional relationships and in her interactions with her peers, she is a pleasure to work with. She is a team player and is respected and appreciated by the other pharmacists and technicians in the outpatient pharmacy.

Sincerely,



David A. Dettle RPh

Attachment T5

June 30, 2009

To whom it may concern:

I have known Noelle Johnson since she came to work for the Veterans Administration Medical Center at Tomah, Wisconsin. I have worked with her in various capacities in the outpatient pharmacy both dispensing prescriptions and counseling patients.

Over that period of time I have had a good working relationship with Noelle and have observed her to be both capable and professional with patients and other healthcare providers. I would not hesitate to work with her again.

Sincerely,



Virginia Schroeder, RPh

Attachment T6

~~Diazepam~~

6/30/09

I have had the opportunity
to work with Noelle Johnson
over the past few months.
Noelle worked in a
professional manner and
was very caring to the
Veterans.

It is a great loss not
to have her as part of our
pharmacy team any longer.

See provided full Prescribing Information, including boxed Warning.

Elaine Chamber P.T.

Lilly

June 11, 2009

In working with Norelle Johnson
I have observed a very professional,
knowledgeable Pharmacist. She made
my job very enjoyable with her
pleasant, upbeat presence. It
was our goal working together
as a team to give Lomah
Veterans the best service possible.

Sincerely,

Kim M. Mulvaney
CPHT
Lomah Memorial OutPatient Pharmacy

TO WHOM IT MAY CONCERN REGARDING NOELLE JOHNSON, CLINICAL RPH,

JUNE 19,2009

ALTHOUGH I DID NOT WORK DIRECTLY WITH NOELLE ON A DAILY BASIS, THE ENCOUNTERS I HAD WITH HER WERE PLEASANT. SHE WAS ALWAYS FRIENDLY AND SMILING WHEN YOU WOULD MEET HER IN THE HALLS. SHE WOULD COME TO OUR POTLUCKS AND PARTICIPATE AND CARRY ON PLEASANT CONVERSATIONS WITH US IN INPT. PHARMACY.

WHEN SHE HAD QUESTIONS ABOUT THE OMNICELLS-SHE WOULD ASK ME FOR HELP AND WAS ALWAYS APPRECIATIVE . ON ONE INSTANCE, I WAS HAVING PROBLEMS WITH THE NARCOTIC SCRIPTS FROM THE OMNICELLS GETTING ENTERED INTO THE COMPUTER BY THE PHARMACIST AND SHE OVERHEARD OUR CONVERSATION AND OFFERED TO HELP FINISH THE ORDERS AND DID SO IN A TIMELY FASHION.

I BELIEVE SHE IS A VALUABLE MEMBER OF THE PHARMACY TEAM.

THANK YOU,

DAWN SCHEPPA

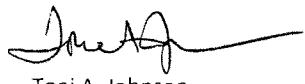
Dawn Scheppa

Attachment T9

6/19/09

I did not work directly with Noelle Johnson on a daily basis. When I did encounter her while working at the VA she was always very friendly.

I was aware that Noelle was a volleyball player and I asked her to help coach a volleyball team for my daughter. Noelle whole heartedly volunteered to do this for me and gave her time freely.



Toni A. Johnson

Attachment T10

19 June 09

re: Noelle Johnson, Pharm D

To Whom It May Concern:

I have had the pleasure of working extensively with Dr. Johnson at TOMAH VA MC.

She is extremely knowledgeable and was of great assistance in managing pain and diabetic patients. She is very professional as well.

Sincerely,

Paul Mass D.O.

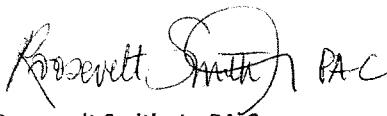
Paul Mass D.O.
Out-patient Dept.
TOMAH VAMC

Attachment T11

To Whom It May Concern:

Re: Noelle Johnson, PharmD.

Over the past year, I have had the opportunity to interact with Miss Johnson. She has been professional, informative, resourceful, and helpful to me.


Roosevelt Smith, Jr. PA-C

Attachment T12

ID: 090395585 PAGE 1 OF 1
 SEE REVERSE SIDE FOR
 IMPORTANT INFORMATION

State of Wisconsin C MC001
 Department of Workforce Development
 Division of Unemployment Insurance

SS # 666-66-7450 UI LO #: 05
 UI Acct #: 996735

DETERMINATION

NOELLE A. JOHNSON
 610 KOZAREK AVE APT 8
 TOMAH WI 54660-1665

VETERANS AFFAIRS
 VA MEDICAL CENTER
 ATTN: HUMAN RESOURCES
 500 E. VETERANS ST.
 TOMAH WI 54660

Issue Week:	27/09	Applicable
Week Ending:	07/04/09	Wisconsin Law: 108.04(5)

FINDINGS AND DETERMINATION OF THE DEPUTY:

THE EMPLOYEE'S DISCHARGE WAS NOT FOR MISCONDUCT CONNECTED WITH HER EMPLOYMENT.

SHE WAS DISCHARGED AS OF 6/30/09 DUE TO CAUSING PROBLEMS WITHIN THE PHARMACY BETWEEN CO-WORKERS AND HERSELF AND REFUSING TO FILL PRESCRIPTIONS. BASED ON THE INFORMATION PRESENTED BY THE EMPLOYER, THE EMPLOYER MAY HAVE MADE A VALID BUSINESS DECISION. HOWEVER, IT HAS NOT BEEN ESTABLISHED THAT HER ACTIONS ROSE TO THE LEVEL TO WARRANT A FINDING OF MISCONDUCT.

EFFECT

BENEFITS ARE ALLOWED.

Attachment U

DEPUTY	DATE MAILED	DECISION FINAL UNLESS A WRITTEN APPEAL IS RECEIVED OR POSTMARKED BY
VIRGINIA BIX	07/21/09	08/04/09

JCB-20 (R 7/24/97) 000212

Ryan Honl Statement

Tomah Congressional Field Hearing

I am the one who blew the whistle on the alarming irregularities concerning unethical practices at the Tomah Veterans Affairs Medical Center. I am also a disabled combat veteran who received care at the VA for 15 years up until last year. I enlisted as a combat engineer after high school, served in Desert Storm, earned an appointment to West Point, then became a commissioned infantry officer before being medically discharged with, among other things, PTSD. It is important to note that I was only the spark to set off years of employees raising concerns about the dangerous prescription and distribution of narcotics as well as the resulting retaliation. The results were to the detriment of the health of veterans and in some cases the deaths of veterans. The system was slow to respond but quick to silence those who raised concerns. I just wish the whistle I blew would resurrect those who have died due to mistreatment. There are three areas where the system broke down.

One, there is a widespread failure of leadership across the VA. That, in the words of the Rob Nabor's White House report issued last year, leads to a corrosive culture that protects corrupt officials from top to bottom and ultimately leads to the harm of veterans. Initially, my complaints to the VA Office of Inspector General mainly centered on a hostile work environment that tolerated fraud and abuse. I only briefly mentioned that although I wasn't a witness to the over prescription of narcotics, there was a widespread concern among my coworkers. I simply stated in my complaint that it should be looked into. The failure in leadership within the Tomah facility centered mainly around Dr David Houlihan and a facility director, Mario Desantis, who was quite simply a rubber stamp. It is a culture where cronyism runs rampant leaving incompetence in charge at all levels that tolerates unethical practices. In a nutshell, I was asked and made aware of unethical behaviors centering on falsely recording time & attendance of a doctor, the loss of personnel files, and tolerance of sending up false reports of the Talent Management System. Once I came out publicly blowing the whistle, I had current and former employees contact me with information about other unethical activities up to and including patient harm and death. There is a lack of accountability in VA leadership. There were years of complaints concerning a retaliatory environment and patient harm, yet both VA leadership and the VA Office of Inspector General ignored or handed off complaints back to the Tomah facility so it could investigate itself. There is a culture in the VA of admitting no wrongdoing and covering it up. Pain management and wait times are simply a symptom of a

far larger lack of accountability. Tomah is not an island unto itself. Dr Houlihan should have been held to account years ago, yet the system protected him and not our nation's veterans.

Two, the VA Inspector General's office is broken. If it weren't for a FOIA request done by Senator Baldwin's office last summer, no one would have known about the issues in Tomah. We wouldn't be sitting here today if it had been public. It took an investigative journalist at the non-profit Center for Investigative Reporting to do the job that the VA Inspector General was incompetent to do. When I received that report through a former colleague whose friend was simply wondering what had happened to their complaints, it was shocking. Everything people had been talking to me about since I blew the whistle was in that report black and white. Excessive prescribing of narcotics. Drug diversion. Patients not using their narcotics. A physician in 2009, Dr Chris Kirkpatrick, who raised concerns about Dr Houlihan's prescribing practices, was terminated, and went home and committed suicide. Tomah municipal police reports of veterans using and selling their medication. Retaliation against those who spoke up concerned about their licenses, such as the 5, let me say again, 5 pharmacists who spoke with investigators about the dangerous levels and early filling of narcotics and resigned or were terminated. Most incredible to me was the statement about the perception of retaliation, implying that it didn't really exist, yet numerous people in the report had been forced out of the facility for simply raising concerns. Perception? No, reality. It doesn't take a rocket scientist or a medical degree to see that something doesn't smell right. Recently, Inspector General Griffin said that he wouldn't have done anything different and no one else would have either. Let me raise my hand with every elected official and whistleblower that something needed to happen far differently. Ms Gromek stated that it couldn't be released because of personally identifiable information. The report received through the FOIA request was redacted. I'll give you two personal examples of retaliation even after resigning from the VA. After requesting a patient access report of my medical records, I discovered that a half dozen Tomah employees had accessed my electronic medical records after I left the facility over a supposed mix up in Secretary McDonald's office concerning a complaint about my prescriptions. Although I had never received care or prescriptions from the Tomah VA, there were half dozen Tomah non pharmacy employees in my records. I had originally informed my supervisor, Lisa Noe, that I had a PTSD diagnosis since I was in vocational rehabilitation and my counselor in Indiana needed to know information about my employment at the Tomah VA. I asked that this remain in confidence. However, as soon as I blew the whistle, I started hearing about my instability from other employees. Ultimately, the most troubling occurred since everything came out in the media in January. Dr Houlihan's attorney sent a letter to me threatening a lawsuit for defamation. In an interview with the Milwaukee Journal Sentinel, his attorney alluded to my mental health status. Shortly after while VA investigators were in the Tomah VA, Police Chief Huffman directed that a police report be done on me by my former supervisor, Lisa Noe, and two coworkers, Leesha Dukes and Rachel Fleming, four months after I resigned over a supposed

"threatening incident" that took place while I was an employee before I resigned. You can see the police report that someone leaked to me in my submitted documents. In one part of the police report, I'm accused of acting "crazy." Clearly, my mental health diagnoses are being used by those I reported in order to discredit me.

Three, of greatest concern are the harmed and dead veterans. The VA has become one of the biggest drug dealers in the nation. It is disheartening to see numerous Dr Houlihan and Deb Frasher patients singing his praises. If you were an addict receiving free narcotics, with some even selling them on the streets, would you be happy that the supply has been cut off? I encourage you to look beyond the fanatical support of those two clinicians and understand why their patients want them prescribing again. Pain medication is necessary. The tragedy is you have two clinicians wildly prescribing and no one within the VA willing to care enough to hold them accountable which is only going to cause the responsible clinicians out there to be more restrictive with those patients that really need that pain medication. I have PTSD. If I were ever prescribed a narcotic to manage it, I'd ask a lot of questions. However, if I had just gotten out of the service and was more vulnerable, I'd trust a physician more. If through that trust I became an addict who knows what would have happened.

In conclusion, there are several things that need to happen. First the good. I believe as do most of the others who are or have raised concerns, that Secretary McDonald is the right guy to tackle the VA's accountability problem. If it weren't for Bob McDonald, none of what has been going on in Tomah for these many years would have been exposed. It was well known within the facility that Bob had published his cell phone number. When I called it, he answered. We didn't talk in any detail about the problems in Tomah, but he listened to what we did talk about. I'm not the only one. Others have had a similar experience. When you have rotten leaders from the bottom to the top, communication becomes the greatest obstacle to changing a culture. By opening up the lines of communication, Bob McDonald has a clearer picture of the problems in the VA than any previous secretary. And that puts the fear of God into the corrupt leaders that would love to see him go and return things to the status quo. The last thing the VA needs is yet another new VA secretary. The greater problem in the VA is an incompetent Inspector General. Until the Secretary is brought up to speed on serious problems, how can he fix what he doesn't know? As both Senator Baldwin and Senator Johnson have done, ask the President to nominate a permanent Inspector General. Finally, elected offices need to make sure that when they hear of serious problems in a facility, they direct those concerns far higher than the facility level. When, as in Tomah, unethical practices go all the way up to the facility director, sending those concerns back to that facility director only leaves the fox to guard the hen house. As Congressman Kind stated, when he came to the Tomah facility last summer, there wasn't a peep from Mario Desantis that there were any problems whatsoever. Nothing. A VA Inspector general should at minimum provide a summary

of problems in a facility. In the case of Tomah, when someone from Congress comes calling, they should already have a topline of any issues concerning investigations. This Inspector General's office didn't even keep senior leadership informed. Carolyn Clancy who will testify today, only found out about the report late last year. Get the President to nominate a new Inspector General and let Bob McDonald continue to clean up and get rid of those who serve themselves instead of veterans. I and others are very encouraged by the efforts of our elected officials to introduce legislation to hold the VA accountable.

Media Documents

- 1) Reporting of Wrongdoing
- 2) Documents of Initially Reported Wrongdoing
- 3) Retaliation BEFORE Resigning
- 4) Retaliation AFTER Resigning
- 5) Secretary Bob McDonald emails
- 6) Senator Letters
- 7) David Houlihan MD Iowa Ethics Complaint and Settlement
- 8) Media Fact Checking

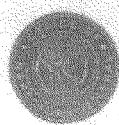
Reporting of Wrongdoing

- 1) Secret VA OIG report, not reported to Congress, obtained by FOIA request through Senator Baldwin's Office
- 2) VA OIG Complaint
- 3) Office of Special Counsel Complaint
- 4) Message sent to Baldwin/Kind/Johnson/Burr concerning Tomah issues
- 5) Rob Nabors White House Report on VA Problems

Scout 016 Report

RA

- not given to Congress
- Clancy just saw it "two months ago"
- nothing Tomah investigation



Administrative Closure
Alleged Inappropriate Prescribing of
Controlled Substances and Alleged Abuse of Authority
Tomah VA Medical Center
Tomah, WI
MCP 1011-04211-HI-0267

Background

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) conducted a review to assess the validity of multiple allegations made by a former employee. Common elements among the concerns included alleged inappropriate and diversion of opioid drugs by a high ranking physician at the facility (Dr. Z) and by a former employee (Dr. Y), as well as abuse of administrative and clinical authority by Dr. Z. The various allegations were compiled from:

*Z - Avolkin MD
Y - Fideler NP*

- * A complaint made in March, 2011 by a patient [REDACTED] (with a corresponding VISN response in June, 2011 and a September, 2011 report from the VISN Chief Medical Officer (CMO) on remedial orders taken).
- * Anonymous complaints made in August, 2011, via a letter sent to the OIG and Congressman Ron Kind of the U.S. House of Representatives.
- * A physician at the facility in March, 2012, while the inspection was already ongoing.

By several anonymous respondents to an E&M survey in May, 2012, that was conducted prior to a regularly scheduled CAP inspection. A total of 13 [REDACTED] were raised by these sources, several of which came to light at various points during the inspection and thereafter.

The scope of our review included the assessment of the patient patterns and associated excessive prescribing habits of Dr. Z and Dr. Y, as well as the administrative interactions of Dr. Z with other doctors and his approach to clinical leadership specifically as it related to abuse of the prescribing of controlled substances. We also sought for any concerns by Federal and non-Federal law enforcement authorities or other agents of drug diversion related to the practice of Dr. Z and Dr. Y. Because of the potential ramifications of the allegations and their responses from multiple sources, the performance of

comprehensive review of the individual practitioners named. Because of the allegations of criminal activity, our efforts throughout this investigation were closely coordinated with the OIG's Criminal Investigation Division (CI).

We reviewed documents from VA and non-VA sources as follows:

- 1. Statement of Charge, Settlement Agreement and Final Order from a state Medical Board concerning charges brought against Dr. Z shortly after his date of appointment to the VA.
- 2. Letters from the Veterans Integrated Service Network (VISN) 12 Director and the VISN 12 CMO.
- 3. Five peer reviews, and correspondence from Dr. Z in the Peer Review Oversight Committee and the VISN 12, regarding allegations made in March, 2011, and subsequent actions by VA management.
- 4. Scope of practice documents and routine peer reviews (2009).
- 5. OIG Master Case Index records of 15 cases at Tomsak VAMC since 2009.
- 6. Ten peer reviews of Dr. Z's practice performed by NewBridge, Inc., following an injury of a patient (2009-2010).
- 7. Peer Review Committee related correspondence between Dr. Z and the Committee.
- 8. Tomsak VAMC police reports of incidents/investigations for a three-year period.
- 9. Reports on adverse drug reactions in patients treated by Dr. Z and/or compiled by the Tomsak VAMC pharmacist.
- 10. Documents related to the conduct of a Tomsak VAMC [REDACTED] professional immediately following termination of employment (memoranda, e-mail messages, Sheriff's Department reports, victim representation records and related internal office correspondence).
- 11. Documents related to the appeal of a terminated Tomsak VAMC [REDACTED] to the Merit Systems Protection Board (MSPB) (appellant's brief for MSPB jurisdiction, narrative of [REDACTED] experiences, supporting materials for decisions).
- 12. Relevant Medical Center Memoranda on pain management, chronic opioid use, and adverse drug event surveillance.
- 13. VA-DOD Clinical Practice Guidelines on Management of Opioid Therapy for Chronic Pain (May, 2010).

*Dr. Clark Kirkpatrick
No
conclusions*

Administrative Closure - MCN # 2011-04212-HI-0287, Tomah VAMC, Tomah, WI

We also requested Tomah VAMC police reports on sales of prescribed or illegal drugs on the Tomah VAMC campus in the preceding three years, but were told there have been no Uniform Offense Reports of such activities.

We conducted general chart reviews as follows:

dr. z and/or

- 1. Patients who were specifically identified in complainants' allegations.
- 2. Patients who were included in June, 2011, peer reviews of Dr. Z's practice.
- 3. A patient ~~officially~~ who was identified by an informant to Tomah municipal police as being involved in drug diversion.
- 4. Selected individuals from a list of the 100 patients at Tomah VAMC receiving the highest doses of opioids.

We also performed structured chart reviews and compiled the results using a SharePoint®-based data entry tool and Microsoft Excel® spreadsheet as follows:

dr. z and/or

- 1. All patients in the care of Dr. Z and/or ~~officially~~ who were among the 100 patients at Tomah having the highest doses of opioids (32 cases).
- 2. Patients on a list provided by the Tomah municipal police department of individuals suspected of drug crimes, who were receiving prescriptions for controlled substances from any provider at Tomah (24 cases). *13 were patients of Dr. Z and/or*

We collected an e-mail dataset for review consisting of 227,512 unique e-mail messages and 859 associated files originating from 17 individuals. This review was performed using Clearwell software. We searched terms that could signal potential drug seeking behavior, such as those related to early refills and urine drug screens, in order to assess what was being communicated about these topics, as well as what advice or instructions were being given. We also reviewed messages pertaining to specific individuals in cases where administrative/supervisory conflicts were reported to exist.

We reviewed several extensive Microsoft Excel®-based datasets derived from pharmacy records with assistance from the VISN 12 Pharmacy Executive as follows:

- 1. Early refills of controlled substances and antidepressants (for comparison) at Tomah VAMC over the period of January 1, 2011 to September 12, 2012.
- 2. Total morphine equivalent amounts of opioids dispensed during FY 2012 in all VISN 12 facilities by site, provider, and patient.

8705
J. Wren

We conducted telephone interviews prior to a site visit, including:

1. The complainant in the case where he/she was not anonymous.
2. Tomah and Milwaukee municipal police officials, a Diversion Investigator from the Drug Enforcement Administration (DEA), United States Department of Justice.
3. Current and former Tomah VAMC staff who were identified by complainant as having key information, including a [REDACTED] a physician, and four pharmacists.
4. The newly appointed Director of Tomah VAMC.

We also engaged the assistance of three pharmacist consultants to assist us in evaluating the clinical and administrative aspects of Dr. Z's interactions with pharmacy staff and the staff's roles in facilitating patient safety and appropriately dispensing controlled substances. We provided the consultants with access to recordings of the interviews with the four pharmacists who had previously left Tomah VAMC.

We conducted a site visit at the facility on from August 22-23, 2012-13. We interviewed the Associate Director (the Director was on sick leave), the Chief of Staff, the Mental Health Associate Chief of Staff, the Chair of the Pharmacy and Therapeutics Committee, the Director of the facility's Opioid Workgroup, the facility's Police Chief, the Pharmacy Director, the Outpatient Pharmacy Supervisor, two clinical pharmacists, six outpatient staff pharmacists, one contract dispensing pharmacist, three psychiatrists, two primary care physicians, a physician's assistant, a [REDACTED] specialist, Dr. Z, and [REDACTED] Y.

During the site visit, we toured the outpatient pharmacy to assess security issues that had been raised in interviews. We also met with the Acting Chief Information Officer to discuss obtaining e-mail files that we were unable to retrieve remotely.

Following the site visit, we conducted several additional interviews by telephone as follows: the Medical Center Director, the Director of Human Resources, and the VISN Pharmacy Executive.

Findings

8705
J. Wren

We did not substantiate allegations that the Tomah municipal and Milwaukee police departments made complaints about drug trafficking at the Tomah VAMC. However, the Tomah police department reported suspicions that certain Tomah VAMC patients were

pharmacy
 duplicitous
 termination
 leaving
 facility

misusing their prescribed controlled substances in various ways including drug diversion.

We substantiated the allegation that at least five outpatient pharmacy staff left the facility in recent years. Pharmacists reported various reasons for leaving. The four pharmacists whom we interviewed expressed concerns regarding the facility's (and ultimately Dr. Z's) expectations for dispensing opioids and other controlled substances. One pharmacist, a new employee, was not retained by the facility at the conclusion of his/her initial employment period. This individual reported that on three occasions he/she had refused to fill prescriptions for controlled substances due to concerns about patient safety and/or drug diversion. A second clinical pharmacist who left the Tomah VAMC reported feeling inappropriately blamed by Dr. Z for the suicide of a patient. A dispensing pharmacist, relatively new to the facility, reported that he believed there were 40-50 patients who were regularly presenting to the outpatient pharmacy for early refills of opioids, and that pharmacists were told by Dr. Z they had to fill the prescriptions. He feared this would place his license at risk. A clinical pharmacist who had been hired in a supervisory capacity reported that when some of the pharmacists expressed discomfort with dispensing high doses of opioids to patients, Dr. Z would become angry and would insist that this pharmacist discipline the other pharmacists under his supervision.

We did not substantiate the allegation that Dr. Z was mismanaging a patient with complex regional pain syndrome by attempting to arrange an inappropriate above the knee amputation.

In the context of having obtained multiple contradictory facts and statements during the course of this inspection, often based on second or third hand accounts, we did not substantiate allegations of abuse of authority, intimidation and retaliation when staff question controlled substance prescription practices.

While we did not substantiate the allegations of abuse of authority, intimidation and retaliation when staff question controlled substance prescription practices, we did find that these are widely held beliefs and concerns among most pharmacy staff and among some other staff.

¹ Additionally, during the course of their investigations of a few deceased veterans they had noted large quantities of prescribed controlled substances in their (the veterans') residences. However, no law enforcement actions were being taken. Early in this inspection we became aware that the DEA was actively investigating complaints of inappropriate prescribing and drug diversion at the Tomah VAMC.

1st
hand
accounts

We found that the Chief of Pharmacy reports to Dr. Z by virtue of his (Dr. Z's) administrative leadership position.

We found that some patients at Tomah VAMC had a pattern of early refill requests, which can be a potential risk behavior for substance abuse. Pharmacists expressed a reluctance to question such early refills. Review of a VISM 12 pharmacy leadership data analysis indicated that Dr. Z, [REDACTED] Y, and other clinicians at the Tomah VAMC provided more than 7 days early controlled substance refills. A pre-April (2, 2012), local facility policy did not allow exceptions to the "no early refill" rule. A newer policy does not prohibit exceptions but does not provide practical guidance, parameters, or processes by which to approach early refills or navigate the clinical complexity of such exceptions.

drugs
2. version
abuse
early
refills

We substantiated the allegation that negative urine drug screens (UDS) are not acted on and that controlled substances are still prescribed in the face of a negative UDS. In the course of our review of selected case histories and from the structured medical record review, we found that for some patients, when a UDS was performed and showed absence of prescribed medication, documentation in progress notes did not always acknowledge this or indicate what, if any, clinical intervention or change in treatment was initiated with the patient. For example, we found in a general chart review of a selected case treated by [REDACTED] Y that multiple negative UDS (i.e., UDS that did not show presence of prescribed medications) were not acted on. In our structured medical record review, 52 of 56 patients had UDS performed at least one time between January, 2009, and April, 2012. The remaining four patients had no UDS performed during this time interval spanning more than three years, although all were treated chronically with opioids during this period. Of the 52 patients who had UDS performed at least one time between January, 2009, and April, 2012, there were five patients who were being prescribed opioids at the time of the negative test, i.e., the test failed to confirm that they were actually taking their prescribed medication.

We did not substantiate the allegation that opioid contracts are not being "encouraged" by Dr. Z. We found that 48 of 56 patients in the structured medical record review had an opioid contract. Of the patients lacking opioid contracts, Dr. Z was a primary prescriber of opioids for none, and [REDACTED] Y was a primary prescriber of opioids for two.

Several allegations dealt with general over prescription of narcotics at the facility, and specifically alleged over prescription by Dr. Z and [REDACTED] Y. The appropriateness of prescribing opioids to a particular patient or the appropriateness of a particular dose utilized is a complex matter that must take into account the patient's history, current

medical and psychiatric status, social situation, and other factors. The clinical decision making underlying this process is based on the practitioner's clinical judgment and other factors that vary from patient to patient. In this context, we did not substantiate the allegations that opioids were prescribed inappropriately to specific individuals or in inappropriate doses.

h3sh
Rx 1/3

However, based on the analysis depicted in Tables 1 and 2 below, we determined that the amounts of opioids prescribed by Dr. Z and [REDACTED]Y in aggregate and to individual patients were at considerable variance compared with most opioid prescribers in VISN 12. Table 1 below shows prescription drug data prepared by VISN 12.

Table 1. Morphine Equivalents Prescribed by each VISN 12 VAMC Station in FY 12.

Station	Total Morphine Equivalents	Unique Patients with Opioid Prescriptions	Total Morphine Equivalents/Unique Patients with Opioid Prescriptions	Average Daily Morphine Equivalents Dispensed (Total Morphine Equivalents/365 days)
676	36,845,093	3173	11,619	100,945
585	28,974,019	3570	8,116	79,381
578	66,814,245	9144	7,307	183,653
807	42,341,117	5891	7,185	116,008
596	21,668,793	3390	6,392	59,387
695	51,990,579	9885	5,258	142,640
537	42,127,193	8582	4,863	115,417

As shown in Column 1 for FY 12, the range among VISN 12 facilities for total morphine equivalents was 21,668,793 to 66,814,245. Tomah was ranked 5th (highest to lowest) of the seven facilities in VISN 12. Column 2 indicates that the facility has the smallest number of patients treated with opioids, which in part may reflect the smaller size of the overall patient population at the facility relative to larger facilities in VISN 12. Column 3 indicates the total morphine equivalents per unique patients treated with opioids. Tomah VAMC ranks highest in this category.¹

VISN 12 provided similar data on a provider level for providers throughout VISN 12. For total morphine equivalents prescribed in FY 12, [REDACTED]Y was highest in the VISN

¹ Tomah VAMC.

¹ It is possible that these numbers may not be directly comparable since larger facilities with more extensive surgical and emergency treatment services likely have more patients that are treated acutely for short time frames with smaller opioid doses. However, data presented suggest this may not be the entire explanation. It can be a factor, as in many other facilities, that the high volume of opioids prescribed in aggregate at the Tomah VAMC is

among 3206 providers who wrote prescriptions for opioids. Dr. Z was the seventh highest opioid prescriber in VISN 12, and a [REDACTED] at Tomah VAMC was the fifth highest prescriber. These three providers accounted for 33.3% of all morphine equivalents prescribed at Tomah VAMC in FY 12.

Table 2: Ten highest individual VISN 12 clinician prescribers (by morphine equivalents) in FY 12

Station	Total Morphine Equivalents	Unique Patients	Equivalencies Determined by Total Quantity Dispensed in FY12		
			Total Morphine Equivalents Rx'd	Avg Daily Morphine Dispensed	Total Morph. Rx'd/365 Days
678 [REDACTED]	5,326,011	182	19,364	14,392	
685	4,311,089	361	11,311	11,543	
578	4,182,868	713	13,260	11,605	
137	3,810,690	311	12,281	10,439	
678 [REDACTED]	3,734,272	332	11,248	10,231	
581	3,489,765	340	10,763	9,380	
674 [REDACTED]	3,238,788	178	25,342	8,837	
578	3,159,204	55	53,184	8,655	
586	2,711,843	107	25,456	23,571	
685	2,427,163	270	8,820	8,450	

Data for the ten highest individual prescribers in the VISN are shown in Table 2. Considering these ten highest prescribers, three were from Tomah VAMC, while two other facilities had two providers each, and the remainder had one or none. Among these ten highest prescribers in the VISN, the total morphine equivalents prescribed for the one year period ranged from 3,238,788 to 5,326,011 morphine equivalents, and morphine equivalents per unique patient ranged from 8,820 to 25,456. Thus, even among these ten highest individual prescribers, there was considerable variation in amounts prescribed. The total morphine equivalents prescribed by [REDACTED] was more than double that prescribed by the tenth highest prescriber in the VISN, and morphine equivalents per unique patient was more than threefold higher.

On a per patient basis, [REDACTED] prescribed 25,456 morphine equivalents per patient (second highest among VISN 12 clinicians) during FY 12, for Dr. Z, the number was comparable (23,571, fourth highest among VISN 12 clinicians). Patient populations will vary from facility to facility, complexity of patient cases may vary from provider to provider, and individual patient characteristics and needs vary from patient to patient. Nevertheless, it seems clear that the total amount of opioid and opioid per patient prescribed by [REDACTED] and

Frasher and
Avolkin work
together

Frasher
Avolkin

Dr. Z are at considerable variance compared with most opioid prescribers in VISN 12, and the data support that total opioid prescribing for one additional individual prescriber at the facility is likewise unusually high.

We did not substantiate the allegation that "Opioids are contraindicated for PTSD, but this is part of [Dr. Z's] treatment plan." In review of patient medical records, emails, and during the course of our interviews we did not find documentation that opioids were being used to treat PTSD. In each case, medical record review indicated a history of a pain related condition and use of opioids for treatment of pain.

At the time of our site visit, Tomah VAMC leadership reported that a Pain Management Committee met on a monthly basis. The Committee was co-chaired by [REDACTED] Y and a primary care physician with a background in pain management. Other members included another physician with a background in pain management, Dr. Z as an adjunct member, a [REDACTED]

One co-chair told us that the Committee addresses mainly administrative issues but that individual clinical cases were addressed by a smaller group of clinicians. This smaller group consisted of [REDACTED] Y, the [REDACTED] and possibly a member of nursing staff not affiliated with the committee. An opioid work group was in the process of being formed. The focus of the work group was to establish surveillance of clinician prescribing patterns. The planned work group included the members of the Pain Management Committee with the addition of the Director of Pharmacy.

Summary and Conclusions

We did not substantiate the majority of allegations made in the various complaints that VMC received. Although the allegations dealing with general overuse of narcotics at the facility may have had some merit, they do not constitute proof of wrongdoing. We did not find any conclusive evidence affirming criminal activity, gross clinical incompetence or negligence, or administrative practices that were illegal or violated personnel policies.

Nevertheless, our inspection raised potentially serious concerns that should be brought to the attention of VISN 12 management for further review. In particular, we noted that the amounts of opioid equivalents prescribed by Dr. Z and [REDACTED] Y, both in aggregate and per individual patient, were at considerable variance compared with most opioid prescribers in the VISN, and that a Tomah VAMC [REDACTED] was likewise prescribing an unusually high total opioid amount. Additionally, while it is true that certain clinicians may be treating patients with unusual conditions that require unconventional treatments,

Frazier NP
co-chair

Administrative Closure - MCI # 2011-04212-H-0257, Tomah VAMC, Tomah, WI

it would seem more clinically appropriate for such complex patients to be treated by a specialist or subspecialist in their particular condition, rather than Dr. Z or other.

Also of concern was the dysfunction of multidisciplinary collaboration in patient care that we observed, particularly between the pharmacy staff and Dr. Z. Perceptions of abuse of authority, intimidation and retaliation are problematic in themselves because they diminish or even preclude the willingness to communicate concerns about potential safety issues or aberrant patient behaviors. From a systems perspective, facility leadership, staff, and ultimately patients and their safety, benefit when there is an environment of communication, collaborative care, approachability, and functional checks and balances. When effective, such collaboration provides a system of checks and balances that reduces medication errors and enhances general patient safety, and is especially important in this setting given the quantities and dosage of opioids that are being utilized in seriously ill patients. The facility appeared to be at a functional impasse with respect to such collaboration. The pharmacy staff uniformly indicated that they were reluctant to question any prescription ordered by Dr. Z or any aberrant behavior by his patients (for example, frequent requests for early refills) because they feared reprisal, even though most of them could not give a first-hand account of negative actions toward them by Dr. Z. For his part, Dr. Z complained that pharmacists (except for one) were unwilling to approach him with problems or concerns and were uninterested in learning more about his treatment approach and rationale.

*perceptions
222*

The Chief of Pharmacy reporting to Dr. Z by virtue of Dr. Z's administrative leadership position may complicate the perception that Dr. Z misuses his authority to compel acquiescence with his clinical decisions.

For patients with complex oncology problems, hospitals often have committees known as tumor boards, comprised of clinicians from multiple disciplines (oncology, surgery, radiation oncology, nursing, nutrition among others) that convene periodically to discuss and recommend an integrated plan for patients with complex cases of cancer.

There are several suggestions that should be brought to the attention of the facility Director and VISN management, as follows:

- The facility Director should implement a vehicle by which clinicians and staff can openly and constructively communicate concerns and rationale when disagreements arise concerning dispensing of opioid prescriptions.

- The facility Director should review the reporting structure in the context of safeguarding bi-directional clinical discourse from actual or perceived administrative constraints.
- The facility Director should ensure development of guidance, parameters, processes, or a specialty clinic based mechanism to assist clinicians and staff with managing complex patients requesting early opioid refills.
- The facility Director should consider some variant of the tumor board model as one potential avenue by which to foster collaborative interdisciplinary management when presented with very complex clinical pain cases.
- The VISN should conduct further evaluation and monitoring of relative and case-specific opioid prescribing at Tomah VAMC on both a facility and individual clinician level.

does not
address
serious/
current
issues

I concur with the recommendation for administrative closure of this inspection. The material in this report will be briefed to VISN 12 Senior Staff including the VISN 12 Director and CMO, and to Tomah VAMC's Director. A report of contact from that briefing will be appended to this administrative closure.

Based on our review, I am administratively closing this case.

John D. Daigle, Jr., M.D.

JOHN D. DAIGLE, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

3/12/14
- signed Phoenix Rpt

- how many other secret reports??

OIG Hotline – Sep 24/2014

Asked to falsify of time & attendance records as a timekeeper

improper maintenance and loss of employee files (lack of records control)

Asked to falsify Talent Management System records to cover personnel who haven't taken training (TMS)

Hostile work environment that produces turnover and very low employee morale. Lack of patient coverage with a doctor who failed to show for work - patients not given proper care in building 403A.

Wrongdoers:

Rachel Fleming

Leesha Dukes

Lisa Noe

Victims:

Tomah VAMC Patients and Staff

Ryan Honl

falsify TMS training records to make the facility report look good (Rachel Fleming)

September 16: Improper T&A Records: Asked to input a normal work day for a doctor (Dr. Ronda Davis) when she failed to report to work.

Ongoing since I started: Improper maintenance and loss of employee files in the service line.

There is a hostile work environment as a new employee. Things were managed improperly before I started as a secretary and I'm being set up to take the blame for it. My supervisor, Lisa Noe, is good friends with my co-workers (Rachel Fleming, Leesha Dukes) that report to her. I have asked Lisa to address these concerns and they have not been addressed. As a new employee I do not feel comfortable in this hostile, unethical environment and wish to claim protections as a whistleblower. I will refuse to participate in this unethical activity and feel that I have been labeled an outsider and very concerned about keeping employed here. I have tried to address my concerns with the union, but am not seeing a resolution. I simply do not know who to trust in the chain of command and if I go higher than my supervisor, I am concerned about retribution. Please contact me anytime, day/night, to further clarify or ask questions.

COMPLAINT OF POSSIBLE PROHIBITED PERSONNEL PRACTICE
OR
OTHER PROHIBITED ACTIVITY

IMPORTANT

Before filling out this Office of Special Counsel (OSC) form, please read the following information about: (1) the required complaint format; (2) the scope of OSC's jurisdiction; and (3) certain OSC policies. OSC cannot investigate a complaint if it lacks jurisdiction over the subject matter. Further, filing a complaint with OSC will not extend any time limits that may exist under any other complaint procedures that may be available. It is important, therefore, that you consider whether OSC may lack jurisdiction over your complaint.

If you plan to file a complaint alleging reprisal for whistleblowing, important information about the elements required by law to establish such a violation is provided in Part 2 of this form (at page 4).

INFORMATION ABOUT FILING A COMPLAINT WITH OSC

Required Complaint Form. Complaints alleging a prohibited personnel practice, or a prohibited activity other than a Hatch Act violation, must be submitted on this form. OSC will not process complaints (except a complaint alleging only a Hatch Act violation) that are not submitted on this form. OSC will return the material received, with a blank complaint form to complete and return to OSC. The complaint will be considered to be filed on the date on which OSC receives the completed form. 5 C.F.R. § 1800.1, as amended.

No OSC Jurisdiction. OSC has no jurisdiction over complaints filed by employees of –

- the Central Intelligence Agency, Defense Intelligence Agency, National Security Agency, or other intelligence agency excluded from coverage by the President;
- the armed forces of the United States (i.e., uniformed military employees);
- the General Accounting Office;
- the Postal Rate Commission; and
- the Federal Bureau of Investigation.

Limited OSC Jurisdiction. OSC has jurisdiction over certain types of complaints filed by employees of some agencies, as follows –

- Federal Aviation Administration employees alleging reprisal for whistleblowing;
- employees of government corporations listed at 31 U.S.C. § 9101 alleging reprisal for whistleblowing; U.S. Postal Service employees alleging nepotism; and
- Transportation Security Administration (TSA) employees alleging reprisal for whistleblowing. TSA non-screener employees may file complaints alleging retaliation for protected whistleblowing under 5 U.S.C. § 2302(b)(8). OSC will process these complaints under its regular procedures, including filing petitions with the Merit Systems Protection Board, if warranted. TSA security screeners may also file complaints alleging retaliation for protected whistleblowing under 5 U.S.C. § 2302(b)(8) pursuant to a Memorandum of Understanding (MOU) between OSC and TSA executed on May 28, 2002. The MOU and TSA Directive HRM Letter No. 1800-01 provide OSC with authority to investigate whistleblower retaliation complaints from screeners and recommend that TSA take corrective and/or disciplinary action when warranted. Additional information on OSC procedures for reviewing security screener whistleblower complaints under the MOU is available at <http://www.osc.gov/tsa-info.htm>.

[over]

VISIT WWW.OSC.GOV

FOR MORE INFORMATION ABOUT OSC JURISDICTION AND COMPLAINT PROCEDURES

COMPLAINT OF POSSIBLE PROHIBITED PERSONNEL PRACTICE OR OTHER PROHIBITED ACTIVITY

Page 6 of 12

MUST BE COMPLETED FOR ALL DISCLOSURES REPORTED IN THIS COMPLAINT

A. WHAT INFORMATION WAS DISCLOSED? <small>(DESCRIBE WHISTLEBLOWER DISCLOSURE.)</small>	
<p>On 9/16/2014, Dr. Ronda Davis, a psychiatrist, did not report for her regular day tours in psychiatric inpatient ward 403A. I was instructed to find her personal contact information in order to find out where she was at. I attempted to contact Dr. Davis along with two other employees throughout my entire shift (7:30am to 4:30pm) to no avail. At the end of the day, I asked my service line manager, Lisa Noe, how I should record Dr. Davis' time & attendance since being a timekeeper is one of my duties. Lisa Noe said, "I don't feel comfortable with it" and said she would check with Dr. Houlihan, Chief of Staff, about how to code it. About 30 minutes later, Lisa Noe returned and I followed up with her again. She said, "It's OK, just record it as a regular day (i.e. that she was present for duty). I did as she instructed. After talking with the two other co-workers about the event, they also agreed that Dr. Davis, in fact, was not present for her shift. I was asked to falsify time & attendance in order to make it look like Dr. Davis had worked her entire shift. According to Lisa Noe, Dr. Houlihan and Dr. [REDACTED]</p>	
B. WHAT INFORMATION WAS DISCLOSED? <small>(DESCRIBE NEXT WHISTLEBLOWER DISCLOSURE.)</small>	
<p>That I was instructed on or about the 2nd week of working in the Mental Health Service line by Rachel Fleming, Program Support Specialist, that it is OK to record doctors as having taken mandatory educational course in the Talent Management System (TMS) in order to "make the reports look good." On or about a week later during TMS training, I asked Tammy Hillyer, TMS Trainer, under what circumstances an authorized TMS supervisor such as myself would enter certification of an employee rather than the employee themselves. She said it is done very rarely and only when the employee has verified that the training occurred if the employee didn't have access to TMS due to computer issues. Shortly after the training, I contacted Tammy Hillyer via the Lync messaging system that I wanted to clarify whether or not what Rachel Fleming told me was correct. She said in no uncertain terms that it would be highly unethical and against regulation for a TMS</p>	
1. WHEN WAS THE DISCLOSURE MADE? (MO/DA/YR) 09/16/2014	
2. TO WHOM (NAME AND TITLE) WAS THE DISCLOSURE MADE? Lisa Noe, Mental Health Service Line Manager	
3. DISCLOSURE OF INFORMATION EVIDENCED (check all that apply): <ul style="list-style-type: none"> <input checked="" type="checkbox"/> VIOLATION OF LAW, RULE, OR REGULATION <input type="checkbox"/> GROSS MISMANAGEMENT <input type="checkbox"/> GROSS WASTE OF FUNDS <input type="checkbox"/> ABUSE OF AUTHORITY <input type="checkbox"/> SUBSTANTIAL AND SPECIFIC DANGER TO PUBLICHEALTH OR SAFETY <input type="checkbox"/> NONE OF THE ABOVE 	
4. WHAT PERSONNEL ACTION(S) OCCURRED, FAILED TO OCCUR, OR WAS THREATENED BECAUSE OF THE DISCLOSURE? (List all applicable personnel action numbers from pages 4-5) (11)	
5. WHEN DID PERSONNEL ACTION(S) OR THREAT(S) OCCUR? (MO/DA/YR) 09/29/2014	
1. WHEN WAS THE DISCLOSURE MADE? (MO/DA/YR) on or about 09/24/2014	
2. TO WHOM (NAME AND TITLE) WAS THE DISCLOSURE MADE? Tammy Hillyer, Education Department	
3. DISCLOSURE OF INFORMATION EVIDENCED (check all that apply): <ul style="list-style-type: none"> <input checked="" type="checkbox"/> VIOLATION OF LAW, RULE, OR REGULATION <input type="checkbox"/> GROSS MISMANAGEMENT <input type="checkbox"/> GROSS WASTE OF FUNDS <input type="checkbox"/> ABUSE OF AUTHORITY <input type="checkbox"/> SUBSTANTIAL AND SPECIFIC DANGER TO PUBLICHEALTH OR SAFETY <input type="checkbox"/> NONE OF THE ABOVE 	
4. WHAT PERSONNEL ACTION(S) OCCURRED, FAILED TO OCCUR, OR WAS THREATENED BECAUSE OF THE DISCLOSURE? (List all applicable personnel action numbers from pages 4-5) (11)	
5. WHEN DID PERSONNEL ACTION(S) OR THREAT(S) OCCUR? (MO/DA/YR) 09/29/2014	

KEEP A COPY OF THIS PAGE FOR YOUR RECORDS

MUST BE COMPLETED FOR ALL DISCLOSURES REPORTED IN THIS COMPLAINT	
<p>C. WHAT INFORMATION WAS DISCLOSED? (DESCRIBE NEXT WHISTLEBLOWER DISCLOSURE)</p> <p>I was unclear about whether or not I was the person responsible for keeping track of personnel files within my office since everyone in the service line has access to the files. My supervisor, Lisa Noe, did not clarify if I was or the procedures on records management of those records. I was repeatedly asked where certain files were by Leesha Dukes, Administrative Assistant, and Rachel Fleming, Program Support Assistant, where files were located. I repeatedly informed them along with my supervisor, Lisa Noe, that I had no idea where they were located, that they were never in my office. I found out later on 09/26/2014 after management found out about my VA OIG complaint, from the Network Director, Dr. Murawsky, when he called me and said that there needs to be a system in place where files are signed out and a card/sheet inserted where the file was in order to track the location of the file at all times. Panic ensued in the Mental Health Service Line when they found out that I had filed an OIG complaint. Rachel Fleming, in the presence of Lisa Noe, instructed me not to give files to anyone, especially the OIG, because there were</p> <p>D. WHAT INFORMATION WAS DISCLOSED? (DESCRIBE NEXT WHISTLEBLOWER DISCLOSURE)</p> <p>That I was repeatedly informed by co-workers that it was not a good idea to inform upper management (i.e. anyone in the Quadrad which consists of the Director, Assistant Director, Chief of Staff, & Assistant Director of Patient Care Services) of any wrongdoing because the Chief of Staff, Dr. Houlihan, would not take care of holding people accountable for wrongdoing and that the Director is a rubber stamp for the Chief of Staff. I was also made aware of investigation that have and are occurring concerning Dr. Houlihan and unethical practices. I was not a witness to most of these unethical practices, but when the Network Director, Dr. Murawsky called me the day the police came and seized the records in my office that Dr. Houlihan was and is under "several investigations." Many employees in the facility are aware of this and feel too intimidated to come forward with knowledge of wrongdoing because the executives never do anything about it and they suspect that it's because Dr. Houlihan himself is under investigations over ethics concerns.</p>	<p>1. WHEN WAS THE DISCLOSURE MADE? (MO/DA/YR) 09/26/2014</p> <p>2. TO WHOM (NAME AND TITLE) WAS THE DISCLOSURE MADE? Lisa Noe, Service Line Manager</p> <p>3. DISCLOSURE OF INFORMATION EVIDENCED (check all that apply):</p> <p><input checked="" type="checkbox"/> VIOLATION OF LAW, RULE, OR REGULATION <input type="checkbox"/> GROSS MISMANAGEMENT <input type="checkbox"/> GROSS WASTE OF FUNDS <input type="checkbox"/> ABUSE OF AUTHORITY <input type="checkbox"/> SUBSTANTIAL AND SPECIFIC DANGER TO PUBLICHEALTH OR SAFETY <input type="checkbox"/> NONE OF THE ABOVE</p> <p>4. WHAT PERSONNEL ACTION(S) OCCURRED, FAILED TO OCCUR, OR WAS THREATENED BECAUSE OF THE DISCLOSURE? (11)</p> <p>5. WHEN DID PERSONNEL ACTION(S) OR THREAT(S) OCCUR? (MO/DA/YR) 09/29/2014</p> <p>1. WHEN WAS THE DISCLOSURE MADE? (MO/DA/YR) 09/24/2014</p> <p>2. TO WHOM (NAME AND TITLE) WAS THE DISCLOSURE MADE? VA OIG Complaint</p> <p>3. DISCLOSURE OF INFORMATION EVIDENCED (check all that apply):</p> <p><input type="checkbox"/> VIOLATION OF LAW, RULE, OR REGULATION <input checked="" type="checkbox"/> GROSS MISMANAGEMENT <input checked="" type="checkbox"/> GROSS WASTE OF FUNDS <input checked="" type="checkbox"/> ABUSE OF AUTHORITY <input type="checkbox"/> SUBSTANTIAL AND SPECIFIC DANGER TO PUBLICHEALTH OR SAFETY <input type="checkbox"/> NONE OF THE ABOVE</p> <p>4. WHAT PERSONNEL ACTION(S) OCCURRED, FAILED TO OCCUR, OR WAS THREATENED BECAUSE OF THE DISCLOSURE? (list all applicable personnel action numbers from pages 4-5) (11)</p> <p>5. WHEN DID PERSONNEL ACTION(S) OR THREAT(S) OCCUR? 09/29/2014</p>
KEEP A COPY OF THIS PAGE FOR YOUR RECORDS	

MUST BE COMPLETED FOR ALL DISCLOSURES INCLUDED IN THIS COMPLAINT

3. If you are not the person who actually made a disclosure described in boxes A, B, C, D above, please check below to specify the disclosure involved, and provide the name, address, and telephone number of the person who made the disclosure, if known. (If space is needed to identify more than one person, use *Continuation Sheet* at page 12.)

Disclosure A () B () C () D ()

Name: _____

Address: _____

Telephone number: () _____ Ext. _____

4. Explain why you believe that the personnel action(s) listed above occurred because of the disclosure(s) that you described. (Be as specific as possible about any dates, locations, names, and positions of all persons mentioned in your explanation. In particular, identify actual and potential witnesses, giving work locations and telephone numbers, if known. Attach a copy of any documents that support your statements. Please provide, if possible, a copy of the notification of the agency's proposal and/or decision about the personnel action(s) covered by your complaint. If more space is needed, continue on page 12.)

When I came to work on Monday, 09/29/2014, several actions occurred leading me to believe that I was/am being retaliated against by Tomah VA Management. Though I was the one trying to do the ethical thing by reporting the above complaints, I was moved out of my service line altogether to the 3rd floor of building 408 across from human resources. I repeatedly inquired through email to my supervisor, Lisa Nee, and acting supervisor, Dr. Skripka, why I could not be placed back in the Mental Health Service Line, that though they had seized my office and computer that there is plenty of space in the service line for me to work. I also was not given a key to access my office on the 3rd floor and had to ask around for someone to let me in. I was told by Dr. Skripka that it was not possible to get a key. I could no longer answer phone calls since they were now routed to Leesha Dukes' line in the mental health service even though they could have been routed to my 3rd floor office. I was instructed by Dr. Skripka that I could no longer be a timekeeper "because of what was going on." Later the Director said he had no knowledge of this duty being taken away from me. I was instructed not to move about the facility unless I reported everything to Dr. Skripka. Before I was allowed, as other employees, to freely move about the facility without asking. Morning Reporting for absent staff was taken away from me and given to Leesha Dukes. I also had to

5. What action would you like OSC to take in this matter (that is, what remedy are you asking for)?

For Department of Veterans Affairs Management to cease all whistleblower retaliation as the VA OIG investigation occurs. Whatever other remedies are available for the emotional stress of dealing with the retaliation. For VA Management to acknowledge that retaliation did/does occur at the Tomah VAMC due to a corrosive culture that prevents employees from raising concerns. For VA Management to create a more welcoming environment for those that raise issues and those that blow the whistle on violations of law, rules, & regulations.

KEEP A COPY OF THIS PAGE FOR YOUR RECORDS

COMPLAINT OF POSSIBLE PROHIBITED PERSONNEL PRACTICE OR OTHER PROHIBITED ACTIVITY
Page 9 of 12

PART 3: CONSENT TO CERTAIN DISCLOSURES OF INFORMATION

OSC asks everyone who files a complaint alleging a possible prohibited personnel practice or other prohibited activity to select one of three Consent Statements shown below. ***IF YOU DO NOT SELECT ONE OF THE THREE CONSENT STATEMENTS BELOW, OSC WILL ASSUME THAT YOU HAVE SELECTED CONSENT STATEMENT 1.*** Please (a) select and sign (or check, if filing electronically) one of the Consent Statements below, and (b) keep a copy of the Consent Statement you select (as well as a copy of all documents that you send to OSC) for your own records. If you initially select a Consent Statement that restricts OSC's use of information, you may later select a less restrictive Consent Statement. If your selection of Consent Statement 2 or 3 prevents OSC from being able to conduct an investigation, an OSC representative will contact you, explain the circumstances, and provide you with an opportunity to select a less restrictive Consent Statement. You should be aware that the Privacy Act allows information in OSC case files to be used or disclosed for certain purposes, regardless of which Consent Statement you sign. See 5 U.S.C. § 552a(b). Information about certain circumstances under which OSC can use or disclose information under the Privacy Act appears on the next page.

(Please sign one)

Consent Statement 1

I consent to OSC's communication with the agency involved in my complaint. I agree to allow OSC to disclose my identity as the complainant, and information from or about me, to the agency if OSC decides that such disclosure is needed to investigate the allegation(s) in my complaint (for example, to request information from the agency, or seek a possible resolution through mediation or corrective action). I understand that regardless of the Consent Statement I choose, OSC may disclose information from my complaint file when permitted by the Privacy Act (including circumstances summarized in Part 5, below).

John A. Zul
Complainant's Signature for Consent Statement 1

10/04/2014
Date Signed

Consent Statement 2

I consent to OSC's communication with the agency involved in my complaint, but I do not agree to allow OSC to disclose my identity as the complainant to that agency. I agree to allow OSC to disclose only information from or about me, without disclosing my name or other identifying information, if OSC decides that such disclosure is needed to investigate the allegation(s) in my complaint (for example, to request information from the agency, or seek a possible resolution through mediation or corrective action). I understand that in some circumstances (for example, if I am complaining about my failure to receive a promotion), OSC could not maintain my anonymity while communicating with the agency involved about a specific personnel action. In such cases, I understand that this request for confidentiality might prevent OSC from taking further action on my complaint. I also understand that regardless of the Consent Statement I choose, OSC may disclose information from my complaint file when permitted by the Privacy Act (including circumstances summarized in Part 5, below).

Complainant's Signature for Consent Statement 2

Date Signed

Consent Statement 3

I do not consent to OSC's communication with the agency involved in my complaint. I understand that if OSC decides that it cannot investigate the allegation(s) in my complaint without communicating with that agency, my lack of consent will probably prevent OSC from taking further action on the complaint. I understand that regardless of the Consent Statement I choose, OSC may disclose information from my complaint file when permitted by the Privacy Act (including circumstances summarized in Part 5, below).

Complainant's Signature for Consent Statement 3

Date Signed

Print

<https://us-mg6.mail.yahoo.com/neo/launch?rand=89mukv059trz69>**Subject:** Email to Wisconsin Congressmen and both Congressional VA Committees**From:** RAH (ryanahoni@yahoo.com)**To:** [REDACTED]**Date:** Saturday, September 27, 2014 8:39 AM*+ Senator Johnson*

This is the message I sent to Wisconsin Senators Tammy Baldwin, Senator Burr, Representative Ron Kind, the Senate Committee on Veterans Affairs, and the House Committee on Veterans Affairs

I want to make you aware of Complaints I have filed with the Office of Special Counsel (case # DI-14-5215), the Veterans Affairs Office of Inspector General (2014-32384), and directly with Secretary Bob McDonald via cell phone and email and Deputy Secretary Sloan Gibson via email. As a disabled combat veteran who receives care at the VA as well as a West Point graduate myself, I must choose the harder right instead of the easier wrong regardless of retribution on the part of Veterans Affairs management. There are grave concerns at the Tomah Veterans Affairs Medical Center concerning patient health and safety potentially resulting in patient suicides which have recently occurred. Since I am unable to leave documents or lengthy copies to cut and paste into your online email system I must cut this short and only leave you with my case numbers concerning this matter (as listed above). I can provide you with additional documentation and am willing to testify before Congress to this wrongdoing. VA OIG and OSC MUST be held accountable to ensure a full, fair and open investigation. Ryan Honi, Secretary (GS-5) 219-379-7621

June 27, 2014

ISSUES IMPACTING ACCESS TO TIMELY CARE AT VA MEDICAL FACILITIES

There is a strong sentiment among many Veterans and stakeholders that in general VA provides high quality health care "once you get in the door" and that the current system needs to be fixed, not abandoned or weakened. The vast majority of VA employees are dedicated, hardworking, and committed to the Veterans they serve. VA doctors, nurses, and staff could choose to work at other facilities, often for greater compensation. They choose to work at the VA because they believe in this Nation's promise to its Veterans, and they work each day to realize that promise and deliver the quality care Veterans have earned and deserve. However, I also believe that it is clear that there are significant and chronic systemic failures that must be addressed by the leadership at VA.

- The 14-day scheduling standard is arbitrary, ill-defined, and misunderstood. The manner in which this unrealistic goal was developed and deployed has caused confusion in reporting and, in some cases, may have incentivized inappropriate actions. It is a poor indicator of either patient satisfaction or quality of care and should be replaced with a more insightful measure.
- The Veterans Health Administration (VHA) needs to be restructured and reformed. It currently acts with little transparency or accountability with regard to its management of the VA medical structure. The VHA Leadership structure is marked by a lack of responsiveness and an inability to effectively manage or communicate to employees or Veterans.
- A corrosive culture has led to personnel problems across the Department that are seriously impacting morale and, by extension, the timeliness of health care. The problems inherent within an agency with an extensive field structure are exacerbated by poor management and communication structures, distrust between some VA employees and management, a history of retaliation toward employees raising issues, and a lack of accountability across all grade levels.
- The Department's failures have generated a high level of oversight. The Department must be more agile and responsive in addressing legitimate oversight inquiries.
- The technology underlying the basic scheduling system used by VA medical facilities is cumbersome and outdated. However, with regard to increasing access to care, the software underlying the scheduling system is secondary to the need for additional resources to actually schedule – doctors, nurses, and other health professionals; physical space; and appropriately trained administrative support personnel.
- Many of the resource issues VA faces are endemic to the health care field (for example, shortages of certain types of specialists, an aging patient base, or geographical shortages around the country) or to the Federal government (for example, slowness in the hiring process or an inability to compete with private sector wages). However, VA has also demonstrated an inability to clearly articulate budgetary needs and to tie budgetary needs to specific outcomes.
- VA needs to better plan and invest now for anticipated changes in the demographics of the veterans. This includes geographical changes, an increased number of female veterans, a surge in mental health needs, an increase in the special needs of younger veterans returning from Iraq and Afghanistan, and specific needs associated with a growing number of older veterans.

ASSESSMENT: ISSUES IMPACTING ACCESS TO TIMELY CARE AT VA MEDICAL FACILITIES

The 14-day scheduling standard is arbitrary, ill-defined, and misunderstood. The manner in which this unrealistic goal was developed and deployed has caused confusion in reporting and, in some cases, may have incentivized inappropriate actions. It is a poor indicator of either patient satisfaction or quality of care and should be replaced with a more insightful measure.

Background:

In 1995, the Veterans Health Administration (VHA) set a 30-day goal for scheduling primary and specialty care medical appointments. In 2011, VHA shortened that goal to 14 days. VHA includes these performance measures in the performance contracts for Veterans Integrated Service Network (VISN) and VA Medical Center (VAMC) directors. VA also includes these measures in its budget submissions and performance reports to Congress. Also from FY2005 to FY2012, the number of appointments scheduled through VHA has increased approximately 19 percent from 5.3 million to 6.3 million.

Recognizing the inherent issues associated with the 14-day scheduling goal, VA has removed it from employee performance contracts.

Observations:

- The 14-day standard creates an unrealistic comparison between VHA and the private sector. Directly comparable data is not available for the private sector, primarily because experts seem to believe that time-to-appointment is only one component of overall patient satisfaction. Further, anecdotal evidence suggests that wait times for appointments are often times equal to, if not longer, in private facilities.
- The performance goal is complicated to compute and to understand because of vagaries around which "date" is being entered. For new patients, wait times are measured from the "create date" or the date on which an appointment is made. For existing patients, the wait times are measured from the "desired date" or the date on which the patient or health care provider wants the patient to be seen. Because the "desired date" is manually entered by a scheduler, it is more susceptible to manipulation. The "create date" is computer-generated date.
- The 14-day standard was included as a measure in employee performance contracts. This may have created an incentive for employees to try to reduce a number over which they personally had very little direct control. In 2010, William Schoenhard, Deputy Under Secretary for Health for Operations and Management, authored a memo detailing a number of "gaming strategies" used to artificially make wait times look lower. Schoenhard noted, "[w]orkarounds may mask the symptoms of poor access and, although they may aid in meeting performance measures, they do not serve our Veterans. They may prevent the real work of improving our processes and design of systems."

Solutions:

- The Department plans to establish a panel of health care experts and industry leaders to catalogue best practices for measuring timely delivery of health care to Veterans and make recommendations to the new Under Secretary for Health.
- Certain performance measures, like wait time data, should be used as management tools to help identify proper deployment of resources but not as a measure of whether high-quality health care has been delivered in an appropriate fashion.

VHA needs to be restructured and reformed. It currently acts with little transparency or accountability with regard to its management of the VA medical structure. In its most modest form, this insularity has impeded innovation and change. In its more extreme manifestations, it has impeded appropriate management, supervision, and oversight. The VHA leadership structure often is unresponsive and unable to effectively manage or communicate to employees or Veterans.

Background:

VHA is America's largest integrated health care system with over 1,700 sites of care, serving 8.76 million Veterans each year. In addition, VHA is the Nation's largest provider of graduate medical education and a major contributor to medical research. In 2013, VA obligated approximately \$150 billion. Approximately 98 percent of total funding went directly to Veterans in the form of monthly payments of benefits or for direct services, such as medical care. The existence of such a vast and geographically widespread field structure makes communication to and from the VA Central Office all the more critical.

Observations:

- VHA delivers quality care, but is resistant to reforms and change. Many recommendations or directives from VA Central Office or from oversight entities are minimized, slowly implemented, or ignored.
- The VHA field structure is not accountable or transparent to Veterans, the Secretary, or the Department as a whole. For example, performance data from the field is often slow to be reported and sometimes openly contested by VAMCs through the press in direct contravention of facts and established procedures.
- The VHA leadership team is not prepared to deliver effective day-to-day management or crisis management. Instead, VHA is marked by an inherent lack of responsiveness and a belief many issues raised by the public, the VA Leadership, or oversight entities are exaggerated, unimportant, or "will pass."

Solutions:

- VA needs increased transparency into the way VHA operates. VHA needs a better structure and more accountability in how to manage the field structure.
- VA Central Office needs to be much more hands on with the VHA field structure.
- The reforms needed at VHA are not political – they are structural and operational. VHA requires significant leadership and management restructuring that:
 - One, allows for increased, consistent flow of information from the VA Central Office to the regional and local field structure; and
 - Two, allows for unobstructed flow of information from the field structure to regional and National management and leadership.

A corrosive culture has led to personnel problems across the Department that are seriously impacting morale and, by extension, the timeliness of health care. The problems inherent within an agency with an extensive field structure are exacerbated by poor management and communication structures, a corrosive culture of distrust between some VA employees and management, a history of retaliation toward employees raising issues, and a lack of accountability.

Observations:

- The vast majority of VA employees are dedicated, hardworking, and committed to the Veterans they serve. VA doctors, nurses, and staff could choose to work at other facilities, often for greater compensation. They choose to work at the VA because they believe in this Nation's promise to its Veterans, and they work each day to realize that promise and deliver the quality care Veterans have earned and deserve.

There is a culture across much of the Department that encourages discontent and backlash against employees. Whistleblower complaints suggest poor management and reflect a palpable level of frustration at the local, regional, and National levels. As an example, approximately one-fourth of all whistleblower cases OSC is currently reviewing across the Federal government come from the Department of Veterans Affairs.

- There is a tendency to transfer problems rather than solve problems. This is in part due to the difficulty of hiring and firing in the Federal government.
- There is culture that tends to minimize problems or refuse to acknowledge problems all together.

Solutions:

- The Department should strengthen management and reporting structures at the VA Central Office and throughout the VHA field structure as referenced above.
- The Department must take swift and appropriate accountability actions. There must be recognition of how true accountability works.
- The tone at the top should encourage employees to speak up about problems, but also to think of and be a part of solutions.

The Department's failures have generated a high level of oversight. The Department must be more agile and responsive in transparently addressing all legitimate oversight requirements.

Background:

There is an incredible amount of oversight on the Department's activities. The IG, OSC, GAO, and several Congressional committees have conducted investigations and reviews into the Department's provision of timely care to Veterans. Over the last 4 1/2 years, VA has provided responses to over 104,000 Congressional inquiries. Over the last 2 1/2 years, VA has responded to over 7,500 requests for policy-related information. And, in the first 6 months of this fiscal year alone, the Department has participated in 33 hearings and 213 briefings for Congress. In the last five weeks, VA has sent over 100 letters to Members of Congress and delivered over 10,000 pages of documents. Twenty-one VA witnesses have provided hours of testimony at 11 hearings. In addition, VA has conducted daily outreach and information exchange between local VA facilities and local Congressional offices. VA has endeavored to be receptive to recommendations and responsive to requests for information – but could still do more.

Observations:

- There have been a number of problems identified and recommendations made by the IG, GAO, OSC, Congress, and others. VA has not followed through on sufficiently addressing those problems or implementing those recommendations.
- The IG is currently conducting investigations at 77 VA facilities. Since at least 2005, GAO and the IG have been identifying concerns regarding scheduling practices and data reliability.
- As of June 23, the OSC had over 50 pending cases, all of which allege threats to patient health or safety. Of those, OSC has referred 29 cases to the VA for investigation. This represents over a quarter of all cases referred by OSC for investigation government-wide. Additionally, 5 U.S.C. § 2302(c) requires agencies to ensure that employees are informed of the rights and remedies available to them under the Whistleblower Protection Act and related laws. OSC has a whistleblower certification program to provide agencies with a process for meeting this requirement. VA is not certified.

Solutions:

- VA should more proactively engage with its various oversight bodies.
- VA should track oversight reports and recommendations. The Department should release quarterly metrics on recommendations made by oversight bodies and VA's response.
- The Secretary should separately meet with the IG, OSC, and the Comptroller General on a quarterly basis. The General Counsel should separately meet with representatives of the IG, OSC, and GAO on a monthly basis.
- The Department should review its process for responding to OSC whistleblower cases (underway), and should designate an official to assess the conclusions and the proposed corrective actions in OSC reports.
- VA should also complete OSC's whistleblower certification program.

The technology underlying the basic scheduling system used by VA medical facilities is cumbersome and outdated. Lack of certain functionalities cause scheduling delays and, in some cases, reporting inaccuracies. However, with regard to increasing access to care, the software underlying the scheduling system is secondary to the need for additional resource to actually schedule – doctors, nurses, and other health professionals; physical space; and appropriately trained administrative support personnel.

Background:

VA began using the VistA electronic health records system in 1985. VistA is the single integrated health information system used throughout VHA in all of its health care settings. VistA is open source and has been used in a number of civilian hospitals.

The VA's VistA system has not changed in any appreciable way since 1985. This system predates the widespread use of the internet. From an engineering or work order management perspective, VistA has many flaws. But, it is state of the art in terms of providing an integrated health record that captures all documentation associated with a patient and it enables the collaboration of the delivery of that care. A 2011 survey by the American Academy of Family Physicians and a similar 2012 Medscape poll found that VistA was better than a large majority of health IT solutions, including those offered by market leaders McKesson and Epic.

VA plans to overhaul the outdated scheduling system and bring an innovative scheduling product into the electronic health record system. VA hopes to award a contract for the new patient-scheduling system by the end of this fiscal year and have the system in place in fiscal 2015.

Observations:

- Dated scheduling systems and practices are causing significant problems for the Department of Veterans Affairs' ability to deliver timely access to quality health care. But neither the systems – nor the schedulers – are the source of extended wait times for Veterans seeking care.
- Many of the resource issues VA face are endemic to the health care field (for example, shortages of certain types of specialists or geographical shortages around the country) or to the Federal government (for example, slowness in the hiring process or an inability to compete with private sector wages). However, VA has also demonstrated an inability to clearly articulate budgetary needs and to tie budgetary needs to specific outcomes.

Solutions:

- Immediate problems with scheduling systems and practices can and are being addressed. The Department will procure new technology and will train frontline personnel on a stronger, modern system.
- VA needs additional resources to ensure adequate and appropriate health care for our Nation's Veterans. Those resources include:
 - Primary Care Physicians
 - Specialty Care Physicians
 - Administrators and Support Staff
 - Space (parking, examination, and surge space)
- VA needs to start planning and investing now for anticipated changes in the demographics of the Veterans. This includes geographical changes, an increased number of female Veterans, a surge in mental health needs, an increase in the special needs of younger Veterans returning from Iraq and Afghanistan, and specific needs associated with older Veterans.
- In the short term, VHA is working to increase the use of contract care. However, VHA must proceed with this carefully as proper oversight of the quality and timeliness of contract care is essential.

Documents of Initially Reported Wrongdoing

- 1) Dr Davis AWOL from duties
- 2) Talent Management System fraud
- 3) Missing personnel Files
- 4) Concerns raised over David
Houlihan narcotics prescribing (see
secret VA OIG report)

VATAS - Welcome

WEBTA™ Employee Timekeeper Inbox [181] Settings Help Log Out

Timekeeper Main Menu > Select Employees >

Timesheet

Employee: DAVIS, RONDA D TL Unit: 676-301
 Pay Period: Timesheet Type: Regular
 18 - 2014 Sep 07, 2014-Sep 20, 2014 P Status: Sent

Day	Hours	Hours Code	Day Tour Code	Env/Haz/Other Code
Week 1 Sun 9/07	1	RG - Regular (Graded)	DO - Day Off	None
Week 1 Mon 9/08	1	RG - Regular (Graded)	DT - Day Tour	None
Week 1 Tue 9/09	1	RG - Regular (Graded)	DT - Day Tour	None
Week 1 Wed 9/10	1	RG - Regular (Graded)	DT - Day Tour	None
Week 1 Thu 9/11	1	RG - Regular (Graded)	DT - Day Tour	None
Week 1 Fri 9/12	1	RG - Regular (Graded)	DT - Day Tour	None
Week 1 Sat 9/13	1	RG - Regular (Graded)	DO - Day Off	None
Week 2 Sun 9/14	1	RG - Regular (Graded)	DO - Day Off	None
Week 2 Mon 9/15	1	RG - Regular (Graded)	DT - Day Tour	None
Week 2 Tue 9/16	1	RG - Regular (Graded)	DT - Day Tour	None
Week 2 Wed 9/17	1	RG - Regular (Graded)	DT - Day Tour	None
Week 2 Thu 9/18	1	RG - Regular (Graded)	DT - Day Tour	None
Week 2 Fri 9/19	1	RG - Regular (Graded)	DT - Day Tour	None
Week 2 Sat 9/20	1	RG - Regular (Graded)	DO - Day Off	None
Week 1 Total	7			
Week 2 Total	7			
Pay Period Total	14			

*WAS
NOT
PRESENT*

Schedule Totals Remarks Leave Balances

Su	M	T	W	Th	F	Sa	Su	M	T	W	Th	F	Sa
09/07	09/08	09/09	09/10	09/11	09/12	09/13	09/14	09/15	09/16	09/17	09/18	09/19	09/20

Day Off Day Tour Day Day Tour Day Day Off Day Off Day Day Tour Day Day Tour Day Day Off Day Off Day Day Tour Day Day Tour Day Off

Work Schedule: F - Full-time AWS Code: O - Not On AWS Permanent Schedule:

Honi, Ryan A.

From: Davis, Ronda D.
Sent: Wednesday, September 17, 2014 11:46 AM
To: Starkey, Cheryl A.
Cc: VHATOM MH Admin, Houlahan, David J.; Finch, Leah B.
Subject: RE: signing documents

Cheryl,

All of the notes on this list are completed and signed. I added notes for _____ as I noticed that they had been inadvertently missed. As you may be aware, Dr. Skripka is covering the acute unit today and tomorrow to allow me to focus on completing the rest of the notes. It is my sincere hope that additional help will be forthcoming for my unit (planned for the second week of October). As I have mentioned before, the current pace is NOT sustainable. Appropriate documentation of each patient interaction is not feasible with the number of patients which I am covering, the rapid turnover of patients and the acuity of these patients. By mid October, you will not need to worry about monitoring my notes or my signing of such notes. Either additional provider support will be in place or it will be clear to me that I need to find a more appropriate practice location because this truly is NOT sustainable.

Sincerely,

Ronda Davis, M.D.

①

Honl, Ryan A.

From: Skripka, David V.
Sent: Thursday, October 02, 2014 6:22 PM
To: Honl, Ryan A.; Martinovich, Jan K.; Brown, Kathryn
Cc: Raap, Kimberly D.; Noe, Lisa H.
Subject: RE: David Alderman is now in T&L 301 in VATAS

Ryan is now able to do timekeeping duties, back to normal. Thanks everyone for your patience!

From: Honl, Ryan A.
Sent: Thursday, October 02, 2014 8:50 AM
To: Martinovich, Jan K.; Brown, Kathryn; Skripka, David V.
Cc: Raap, Kimberly D.
Subject: RE: David Alderman is now in T&L 301 in VATAS

Thanks Jan. Hopefully I'll be able to perform my duties at some point again.

From: Martinovich, Jan K.
Sent: Thursday, October 02, 2014 8:45 AM
To: Honl, Ryan A.; Brown, Kathryn; Skripka, David V.
Cc: Raap, Kimberly D.
Subject: RE: David Alderman is now in T&L 301 in VATAS

Ryan,

Payroll will need an updated Timekeeping Authorization Memo to remove your timekeeping tab and take you out of VATAS.

Thank You.

Jan K. Martinovich
 Payroll Technician

Department of Veterans Affairs
 500 E. Veterans St. (04D)
 Tomah, WI 54660



Proudly Serving America's Veterans!

(2)

From: Honl, Ryan A.
Sent: Thursday, October 02, 2014 8:39 AM
To: Martinovich, Jan K.; Brown, Kathryn
Subject: RE: David Alderman is now in T&L 301 in VATAS

Hi Jan,

Just wanted to let you know I've been instructed by Dr. Skripka to no longer perform timekeeping duties, so Kathy is going to have to do it all from this point forward until I hear any different.

From: Martinovich, Jan K.
Sent: Wednesday, October 01, 2014 8:45 AM
To: Honl, Ryan A.; Brown, Kathryn
Subject: David Alderman is now in T&L 301 in VATAS

FYI-
Please set his schedule and post his timesheet for PP 20.
Jan

(1)

Ellinghuysen, Linda

From: Honl, Ryan A
Sent: Thursday, September 25, 2014 3:29 PM
To: Lane-Belcher, Tracey
Cc: Hensley, Lori; Ellinghuysen, Linda
Subject: RE: ****PLEASE READ****

Tracey,

I am more than happy to meet with you or anyone else with a union rep.

Ryan Honl
 Secretary
 Mental Health Service Line
 Department of Veterans Affairs
 500 E. Veterans St.
 Tomah, WI 54660
 E-mail: ryan.honl@va.gov
 Phone: (608) 372-3971 ext 61631
 FAX (608) 372-1224

From: Lane-Belcher, Tracey
Sent: Thursday, September 25, 2014 12:24 PM
To: Honl, Ryan A.
Cc: Hensley, Lori
Subject: RE: ****PLEASE READ****

Ryan,
 Thank you for the email. Tammy Hillyer contacted me anonymously. I did not have any names until your recent email.
 I understand that you are not willing to discuss the situation without union representation.

However, some of the information you reported to Tammy placed her in a difficult situation in which she must report the privacy violation, as well as me. Without your input of the exact events, it is difficult to understand if this was a simply misunderstanding and only requires re-education. I wanted you to be aware as we discussed so there were no surprises. I really want to understand the use of your TMS account by another employee and help you be successful in future endeavors with TMS, as well as anyone else involved in the situation.

I understand that your leadership is aware- Lisa Noe and I will need to inform her regarding the privacy violation but will not be able to provide any details per your response.

I am truly sorry you are in this situation and I hope you understand the ethical obligation that Tammy Hillyer and me have regarding the use of your TMS account by another employee.

Thanks,

From: Honl, Ryan A.
Sent: Thursday, September 25, 2014 8:04 AM
To: Lane-Belcher, Tracey
Cc: Hensley, Lori

(2)

Object: ****PLEASE READ****
Importance: High

Tracey,

Tammy Hillyer requested that I contact you regarding a TMS issue that she said she informed you about. I just want you to know that I request union representation before speaking with anyone in the facility about this matter.

Ryan Honl
Secretary
Mental Health Service Line
Department of Veterans Affairs
500 E. Veterans St
Tomah, WI 54660
E-mail: ryan.honl@va.gov
Phone: (608) 372-3971 ext 61631
FAX (608) 372-1224

Print

<https://us-mg5.mail.yahoo.com/neo/launch?rand=16u86h566egno&...>

①

Subject: [No Subject]
From: Honl, Ryan A. (Ryan.Honl@va.gov)
To: ryanahonl@yahoo.com, [REDACTED]
Date: Wednesday, September 24, 2014 5:40 AM

Honl, Ryan A. [6:26 AM]:
Hi Tammy, are you available to talk right now. Extension?

Hillyer, Tammy A. [6:26 AM]:
give me a few mintues to finish what I'm working on

Honl, Ryan A. [6:26 AM]:
ok thanks.

Honl, Ryan A. [6:30 AM]:
feel a little uneasy about what I'm being asked to do about recording TMS training for staff who haven't done it.

Hillyer, Tammy A. [6:31 AM]:
For Good Reason. What's your number. I'll call you shortly

Honl, Ryan A. [6:32 AM]:
actually leisha just walked in and I'm not comfortable to discuss over the phone now

Hillyer, Tammy A. [6:32 AM]:
can I talk in confidence in your office?

Hillyer, Tammy A. [6:32 AM]:
Call me at 61131 when you can. I Telework

Honl, Ryan A. [6:33 AM]:
according to rachel fleming it's ok to document that work has been completed among the doctors when it has not so the reports look good and you stop bothering us

Hillyer, Tammy A. [6:34 AM]:
That is ABSOLUTELY WRONG and in an event of an audit, records will show WHO recorded that training.

[Print](#)<https://us-mg5.mail.yahoo.com/neo/launch?.rand=16u86h566egno#1...>

What is the training you've been asked to record?

Honl, Ryan A. [6:36 AM]:

might be good to run that report for before I came on. now that TMS is my responsibility to track, the heat is on and am worried about retribution. very hostile here. I've been asked to do it anytime doctors don't meet critical education training that it's ok. I have not done that.

Hillyer, Tammy A. [6:37 AM]:

That's disturbing

Honl, Ryan A. [6:37 AM]:

I realize I'm probably screwed and need to look elsewhere for employment but oh well

Ryan Honl

Secretary

Mental Health Service Line

Department of Veterans Affairs

500 E. Veterans St

Tomah, WI 54660

E-mail: ryan.honl@va.gov

Phone: (608) 372-3971 ext 61631

FAX (608) 372-1224

**DEPARTMENT OF
VETERANS AFFAIRS**

Memorandum

Date: October 7, 2014

To: Ryan Hens, Secretary, Tomah VA Medical Center

CC: Maria V. DeSantos, Director, Tomah VA Medical Center
David Dechant, Human Resources Officer, Tomah VA Medical Center
John B. Jones, Special Agent, Office of Inspector General

From: Michael T. Newman, Assistant Regional Counsel, Region 15

Subject: Inspector General Close-Out

Dear Mr. Hens:

It is my understanding that you met with Perry Huffman, Tomah VA Police Chief, on September 26, 2014, to discuss various concerns that you had raised. Chief Huffman forwarded your concerns to the Office of the Inspector General, which opened a file on your case (VA OIG File No. 2014-05176-DC-0193).

I am writing to inform you that on October 1, 2014, the Office of Inspector General contacted our office and advised that it determined your concerns were administrative in nature and it would not be conducting any further investigation. Your concerns have therefore been referred for administrative review.

If you have any questions about the Office of Inspector General file, please contact Special Agent John B. Jones at (703) 203-2199. If you have any questions about the status of the administrative review, please contact Diane Fletcher, Human Resources Officer, at (703) 203-1971 ext. 61171.

MTN

b-a:jlh/10/2014

DEPARTMENT OF
VETERANS AFFAIRS

Memorandum

DRAFT - This document contains neither recommendations nor conclusions of the Department of Veterans Affairs. It reflects the views of the author only.

Date: October 7, 2014

To: Alternate Privacy Officer (PA)

Re: Following Privacy Ticket PIA-13000017670

Subject: Medical Center Director (MD)

1. In my role as Alternate Privacy Officer, I was asked to complete an audit of the Mental Health Service Line Personnel Records in regards to a previous allegation filed on September 18, 2014 stating some of the records were missing.
2. A thorough review of all files in the cabinet was completed by the Alternate Privacy Officer (PA) on October 7, 2014 within the Tampa VA Medical Department. The review included reviewing three drawers of a file cabinet (1) that held the employee personnel files.

According to the original complaint, 68 records were connected to an allegation of 16 highlighted areas for investigation. My findings are listed below in order of the highlighted marks on the original complaint:

- (1) New employee in mental health and the trifolder is still with Patient Care Services
- (2) Employee is a new employee and would not have a PI folder at this time
- (3) Employee's general folder was in the file cabinet and was not missing as suspected
- (4) Employee is a health tech and would not require a PI folder
- (5) Employee's trifolder was in the file cabinet and not missing as suspected
- (6) Employee's general folder was in the file cabinet and not missing as suspected
- (7) Employee is a new employee and the general folder is currently in personnel
- (8) Employee's trifolder was located in the Chief of Staff for Mental Health Service's file
- (9) Employee is an administrative assistant and would not require a PI folder
- (10) Employee is a Fee Basis provider and would not require similar personnel files as others
- (11) Employee is a Physician Assistant and would not require a PI folder
- (12) Employee's general folder was located in the file cabinet and not missing as suspected
- (13) Employee is a Physician Assistant and would not require a PI folder
- (14) Employee is a Physician Assistant and would not require a PI folder
- (15) Employee is a Fee Basis provider and would not require the same files
- (16) Employee is a new employee and the general folder is currently in personnel or awaiting

4. Additionally, out of the 68 records, 37 records were complete to include a trifolder, PI folder, and general folder. 31 records were personnel who would not require a PI folder therefore they were not included in the file. Two records were Fee Basis providers who did not require the same documentation as other personnel. Five records were new providers whose records are in the process of being created the files are awaiting other service lines to send the trifolder to the Mental Health Service line for review. Five records were employees of the Director or Chief of Staff and the records are located with that service, and one record was a trifolder that was located in another Mental Health Office for review.

In conclusion, none of the allegations were found to be upheld/founded. It is recommended the file content be referred to the Mental Health Service Line. A recommendation to the Mental Health Service in order to avoid this type of allegation in the future, create a check-out system whereby records are be accounted for at all times. Additionally, if a record is checked-out the employee checking the record out is responsible to properly secure the documents.

8. If there are any questions or need for further review please ask. The PLET team for your requested to be closed at the National Kennedy Level.



Leah Frazee MFTL

Altavista Privacy Officer

C.
Chief of Staff
Mental Health
Poles
Human Resources
Privacy Officer



Retaliation BEFORE resigning

- 1) Union emails referencing retaliation
- 2) Before/After reporting wrongdoing
list
- 3) Resignation Letter

Ellinghuysen, Linda

From: Hannan, Daniel P
Sent: Wednesday, October 08, 2014 12:01 PM
To: Ellinghuysen, Linda; Hensley, Lori
Cc: Honl, Ryan A.
Subject: VISN meeting 10/2

Meeting from 10/2 @ 11:25 in AFGE conference room requested by management to question Ryan.

Present:
 Edward Landreth- VISN MH lead
 Sharla Parker- VISN compliance and privacy officer
 Ryan Honl-Employee
 Daniel Hannan- AFGE

Dr. Landreth stated that this meeting was to ONLY to gather information for an external review. Although he stated this he and Ms. Parker were not interrupting or stopping Ryan when he occasionally offered some evidence. There were 6 concerns that they took from Ryan at the meeting:

1. Ryan stated he was being retaliated against for coming forward and telling the truth. Ryan offered a couple of pieces of evidence.
2. Ryan was asked by his supervisor Lisa Noe to code Dr. Davis as working a normal day on 9/16 when at the time she was an unexpected no show.
3. Ryan was asked to falsify TMS documents. Ryan offered a couple of pieces of evidence.
4. Ryan stated that some personnel files are missing from the MH service line.
5. Dr. Houlihan has a history of unethical conduct at the Tomah VA and he is not one to go to with ethical issues
6. There is an overall mistrust of Tomah VA leadership and management that is based on a long culture of favoritism and retaliation.

Of note,

Dr. Landreth and Ms. Parker initially stated they were going to talk to several people however after talking to Ryan they conferred privately and decided they changed their mind and did not want to talk to anyone. It is my opinion that they did not want to know any more RFAI facts in an effort to keep the future investigation as narrow as possible in an attempt to protect the MH service line, Tomah Management, and Tomah leadership.

Quality Comprehensive Care. Every Veteran. Every Day.

Dan Hannan RN, MSN
 Psychosocial Rehabilitation and Recovery Center
 ext: 66498 [REDACTED]
 VA Medical Center
 500 E. Veterans St.
 Tomah, WI 54660

(3)

Ellinghuysen, Linda

From: Ellinghuysen, Linda
Sent: Tuesday, September 30, 2014 9:39 PM
To: Skripka, David V.
Cc: DeSanctis, Mario V.; Lane, Tobin; Dechant, David P.; Steinhoff, Angela R.; Hensley, Lori; Murawsky, Jeffrey; McDonald, Bob; Bevins, Debi; Houlahan, David J.; Noe, Lisa H.; Hensley, Lori
Subject: RE: Whistleblower Protection

Dr. Skripka,

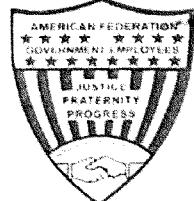
As a psychiatrist, one should be able to expect that you be able to give clear directions to an employee. Telling a fairly new employee that he should use his personal phone to text you before he leaves the office is an unclear message; thus, I became involved to ensure a clear message was given and also received. Of course the Union does not object to "any" practice whatsoever that would have employees let a supervisor or co-worker know if they if they will be unexpectedly away from their normal work area."

You state that Ryan Honi was away from his "post" for an extended period of time last week. Did a supervisor speak to Mr. Honi about this? This is certainly the first I am hearing of this and I've been working with Mr. Honi ever since he received Whistleblower Protection. Our time can be better spent putting our time and talent into fixing what is broken here instead of pointing fingers at a new employee who is just trying to do the Right Thing.

New employees need clear direction and excellent orientation to their work. This has not occurred for Mr. Honi. In fact, I told Mr. Honi this week that he is entitled to a 15min. break in the morning and a 15min. break in the afternoon along with his 30min. lunch break; he appeared to be surprised he received two 15min. breaks.

There needs to be less harassment in the work place within Mental Health and more welcoming orientation. The hostility and harassment must stop. Mental Health Service Line loses providers all of the time because they are treated so poorly, but, then, you know this first hand.

Lin Ellinghuysen
 Acting President
 AFGE Local 6007 AFL-CIO
 VA Medical Center
 Towson, MD 21202
 office: 402-372-3878
 [REDACTED]



(3)

From: Skripka, David V.
Sent: Tuesday, September 30, 2014 5:56 PM
To: Ellinghuyzen, Linda
Cc: DeSanctis, Mario V.; Lane, Tobin; Dechant, David P.; Steinhoff, Angela R.; Hensley, Lori; Murawsky, Jeffrey; McDonald, Bob; Bevins, Debi; Houlahan, David J.; Noe, Lisa H.; Hensley, Lori
Subject: RE: Whistleblower Protection

Lin,

Mr. Honl had reportedly left his post last week for several hours straight, without telling his supervisor that he was leaving. I thought it would be very much in Mr. Honl's interest, as well as a good practice for me as the acting supervisor that afternoon, for him to give me a heads up if he was going to leave his "post". My concern was wanting to make sure he would be covered against any possible perceptions that he was away again from his workplace without leave or notice. I did clarify with him today that this does not include leaving for routine tasks, going downstairs to the mental health office suite, etc. I also clarified that email, or whatever form of communication works best for him, is OK.

All the employees working in the MH admin suite, including Mr. Honl previous to last week, have generally been conscientious about letting others know if they are gone for any significant length of time other than scheduled meetings. I would not object to Mr. Honl letting others (such as co-workers) know if he finds this preferable, although given his location and his reported conflict I thought it would be most sensible that he let me know directly.

Does the union object to any practice whatsoever that would have employees let a supervisor or co-workers know if they will be unexpectedly away from their normal work areas?

Respectfully,

David Skripka, MD
 Associate Chief of Staff for Mental Health
 Tomah VA Medical Center
 500 E. Veterans St.
 Tomah, WI 54660
 (608) 372-1631 (office)
 (608) 567-1630 (cell)
 (608) 372-1224 (fax)

From: Ellinghuyzen, Linda
Sent: Tuesday, September 30, 2014 12:49 PM
To: Skripka, David V.
Cc: DeSanctis, Mario V.; Lane, Tobin; Dechant, David P.; Steinhoff, Angela R.; Hensley, Lori; Murawsky, Jeffrey; McDonald, Bob; Bevins, Debi; Houlahan, David J.; Noe, Lisa H.; Hensley, Lori
Subject: RE: Whistleblower Protection

Do you and/or the other supervisors demand this same accountability from the other bargaining unit employees; wherein, they are to notify a supervisor before they leave their office – for anything other than restroom purposes? I think not. However, if I am incorrect – which employees must check in with supervisors before they leave the Mental Health Suite for anything other than their breaks?

What specifically is your rationale for imposing this restriction solely upon Mr. Honl? Is there fear that Honl may make a private phone call? That he may visit the Union Office? What is your fear or concern based on?
 By the way, Mr. Honl is aware that he is to inform a supervisor if he visits the union office anytime outside of his two 15-minute breaks and/or his 30 minute lunch break.



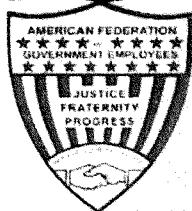
/ Honi is to be treated similarly to the other bargaining unit employees working within the Mental Health Service line.

Thank you,

Linda Ellinghuysen

Acting President

AFGE Local 5007 AFL-CIO
VA Medical Center
Tomah, WI 54660
Office: 608-372-3878



From: Skripka, David V.
Sent: Tuesday, September 30, 2014 12:39 PM
To: Ellinghuysen, Linda
Cc: DesSantus, Mario V.; Lane, Tobin; Dechant, David P.; Steinhoff, Angela R.; Hensley, Lori; Murawsky, Jeffrey; McDonald, Bob; Bevins, Debi; Houlihan, David J.; Noe, Lisa H.
Subject: RE: Whistleblower Protection

Lin,

I just returned to my office recently, and just spoke with Ryan by phone. I'll send a more full response this afternoon. I'll clarify issue #2 below. Yesterday, in my role acting as supervisor on behalf of Lisa Noe in her absence, I directed Mr. Honi to contact me directly to let me know if he were to leave his work area. It was not my intention that he do so prior to using the restroom, nor do I have any desire to "imprison" him. I wanted to maintain some knowledge/accountability of his whereabouts, and to avoid a situation where he would be away from the work area for an extended period of time without my awareness.

I clarified this with Ryan just now, and we touched base on the other issues. I'll meet with him further in approximately an hour.

Respectfully,

David Skripka, MD
Associate Chief of Staff for Mental Health
Tomah VA Medical Center
500 E. Veterans St.
Tomah, WI 54660
(608) 372-1631 (office)
(608) 567-1630 (cell)
(608) 372-1224 (fax)

(5)

From: Ellinghuysen, Linda
Sent: Tuesday, September 30, 2014 11:00 AM
To: Skripka, David V.; Houlihan, David J.; Noe, Lisa H.
Cc: DeSanctis, Mario V.; Lane, Tobin; Dechant, David P.; Steinhoff, Angela R.; Hensley, Lori; Murawsky, Jeffrey; McDonald, Bob; Bevins, Debi
Subject: Whistleblower Protection

AFGE Local 0007 represents Mr. Ryan Honl, GS-5, Secretary in the Mental Health Service Line.

Last Friday, September 26, 2014, I e-mailed and left voicemail to several of you in an attempt to find a workplace for Mr. Honl to report to this week Monday, September 29, 2014 – since the Director stated that Mr. Honl should have a workspace outside of the Mental Health suite of offices.

Yesterday morning at approximately 7:30a.m. I phoned and spoke with Human Resource Officer (HRO) Mr. David Dechant. It was agreed that Mr. Honl would stay in the Union Office until a vacant office was located. At approximately 12:30p.m. I escorted Mr. Honl to building 408, 3rd floor, and introduced Honl to David Dechant, HRO. Waiting for Honl outside a vacant office, which is located across from the HR Suite of Offices on building 408, was Dr. Skripka, Psychiatrist/Associate Chief of Staff for Mental Health. I left Ryan Honl with Dr. Skripka, who was prepared to give work assignments to Honl.

NOTE: The Mental Health Suite of Offices is in building 407, which is quite a distance from the current office Honl is using on 408.

In the meantime, Mr. Dechant, HRO, is looking into getting Honl back into the Mental Health Suite of Offices. As of this writing, Honl remains in the vacated office on a building away from the Mental Health offices.

CONCERNS:

1. Ryan Honl has been taken away from his assigned work area; (note: Mr. Dechant and I did have cordial discussion re. this issue.);
2. Yesterday, Monday, September 29, 2014, Dr. Skripka told Ryan Honl that if he wants to leave the office on 408, 3rd floor, that he is to use his personal cell phone to text Dr. Skripka. Per Honl, no rationale was given to him as to why this is required. I am unaware of any other employee receiving same or similar directions – and I've worked here 29 years.

Please give rationale for this order of "false imprisonment" / "physical confinement."

(Consider, also, that some employees have limited cell phone plans for texting.)

3. Ryan Honl does not have a key to the vacant office he is using and called a Mental Health co-worker to protect the information contained within the office so Honl could use the restroom. I told Honl that he did not have to text a supervisor to use a restroom. If anyone takes issue with this, feel free to give me a telephone call, # is below.

Additionally, perhaps a key could be signed-out to Mr. Honl for the day so that he can go to the restroom and will be able to secure private/confidential information behind locked doors.

4. At this time, Mr. Honl is in need of work assignments. Please refer to an e-mail he sent to Mental Health supervisors earlier this morning.

6

5. If management has any question as to when Ryan Honl spoke with the Union, which I understand there is, feel free to telephone the # below. AFGE Local 0007 represents Mr. Honl; and, we have the answers regarding this important issue for some of management.

Respectfully Submitted,

Lin Ellinghuysen

Acting President
AFGE Local 0007 AFL-CIO
VA Medical Center
Tomah, WI 54660
Office: 608-372-3878



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①

cid:image003.jpg@0

From: Murawsky, Jeffrey
Sent: Friday, September 26, 2014 1:35 PM
To: Ellinghusen, Linda
Cc: McDonald, Bob; Gibson, Sloan; Bevins, Debi; Brahm, Victoria P; Brandt, Marc A. VISN 12; Iacovetti, Chris; Mansell, Kathryn; Mehta, Praveen ; Olson, Robin (VISN 12); Oshinski, Renee; Zimmerman, Joseph (VISN 12); DeSanctis, Mario V.; Lusk, Ike; Enobakhare, Yettalevette E.; Pinckney, Kim; Stewart, James T. (VHACO); White, Christina (VHACO)
Subject: RE: Follow-Up on OIG Report

Lin,

Dr. Landreth will visit and we will let you know the dates next week to do the review. The files will remain locked; however, if Dr. Landreth needs to review them he would have to do so under Police control so as to maintain the integrity of the documents. My desire is to have Dr. Landreth in is to provide some expediency to a look into this. If there is not a clear path forward after this review we will invite an external VHA group (from outside the VISN) and will discuss that with you after next week's fact finding. Again I expect the Dr. Landreth will provide an objective assessment, without regard to any past interaction with your local leadership.

Best,

Jeff

Jeffrey Murawsky, MD FACP
Network Director, VISN 12

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From: Ellinghuysen, Linda
Sent: Friday, September 26, 2014 1:27 PM
To: Murawsky, Jeffrey
Cc: McDonald, Bob; Gibson, Sloan; Bevins, Debi; Brahm, Victoria P; Brandt, Marc A. VISN 12; Iacovetti, Chris; Mansell, Katheryn; Mehta, Praveen ; Olson, Robin (VISN 12); Oshinski, Renee; Zimmerman, Joseph (VISN 12); DeSanctis, Mario V.; Lusk, Ike
Subject: RE: Follow-Up on OIG Report
Importance: High

Dr. Murawsky ~

To Clarify and ensure complete understanding, will you please respond to the following queries:

#1 - Dr. Edward Landreth will be visiting the Tomah VAMC sometime the week of September 29 2014 to conduct an informal Fact Finding regarding the concerns expressed by Ryan Honl, employee, and by other employees;

#2 - The Files within the File Cabinet and the computer found in Ryan Honl's work area will remain secured as Evidence until the OIG Investigation; with solely the OIG first viewing this evidence.

I do not know Dr. Landreth; therefore, I am not questioning his integrity. At the same time, when we know Dr. Landreth and Ms. Noe have a close relationship, one must question the integrity of the process and AFGP does question the integrity of the proposed process.

Stating this for clarification.

Respectfully,

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Lin Ellinghuysen
Acting President
AFGE Local 0007 AFL-CIO
VA Medical Center
Tomah, WI 54660
Office: 608-372-3878

[REDACTED]

[REDACTED] cid:image003.jpg@0

(3)

From: Murawsky, Jeffrey
Sent: Friday, September 26, 2014 12:59 PM
To: Ellinghuysen, Linda
Cc: McDonald, Bob; Gibson, Sloan; Bevins, Debi; Brahm, Victoria P; Brandt, Marc A. VISN 12; Iacovetti, Chris; Mansell, Katheryn; Mehta, Praveen; Murawsky, Jeffrey; Olson, Robin (VISN 12); Oshinski, Renee; Zimmerman, Joseph (VISN 12); DeSanctis, Mario V.; Lusk, Ike
Subject: RE: Follow-Up on OIG Report

Lin,

I am sorry if there was a miscommunication about the intent and number of reviews to occur. Dr. Landreth, our VISN Mental Health Lead, is coming to look into any concerns that have been raised into the specific issues next week while we are at the Labor Forum, which is something I can do with a sense of more immediate urgency. I expect him to function and act appropriately and with integrity to look into anything discussed and provide a thorough report. This visit is a fact finding and not meant to replace any external reviews, but to understand the concerns raised provide a forum to hear them and address any patient care impacts more urgently. This visit will not impact any reviews by the Office of Special Counsel, the Office of the Inspector General or other external reviews. I expect that those will occur and

(4)

we will fully cooperate when they occur; however, I cannot speak to nor control the timing of these reviews but as you noted, we have taken action to ensure the information referenced is controlled appropriately while awaiting a review to occur. If concerns exist after Dr. Landreth's visit we can discuss what type of external team you might believe would provide the best insight to improve operations and the care provided while the formal external reviews are completed.

Best,

Jeff

Jeffrey Murawsky, MD FACP

Network Director, VISN 12

From: Eilinghuysen, Linda
Sent: Friday, September 26, 2014 12:44 PM
To: Murawsky, Jeffrey
Cc: McDonald, Bob; Gibson, Sloan; Bevins, Debi
Subject: Follow-Up on OIG Report

Dr. Murawsky ~

There is need for swift communication to each of you due to the following:

1. Tomah, WI VAMC Director informed us that next week there will be an VISN Independent Investigation done by Dr. Edward Landreth from the VISN. We do not feel comfortable with these arrangements for the following reasons:

a. Dr. Landreth and Mental Health Service Line Manager are on a first name basis and very friendly;
b. A thorough unbiased Investigation is needed to find out if there is or is not Waste, Fraud, and Abuse occurring within this facility – we do not want any cover-up.

2. On behalf of Mr. Honi and all bargaining unit employees working at this facility, AFGE union requests there be an Investigation conducted by OIG.

Print

<https://us-mg5.mail.yahoo.com/neo/launch?rand=16uL6u3000m106...>

(5)

3. Mr. Honi and I met this morning with Tomah VAMC Medical Center Director, Mr. DeSanctis and with Chief of Police Huffman. The file cabinet with files and the computer used by Mr. Honi are now in Evidence. A new lock has been put on the office door of Mr. Honi's work area.

Lin Ellinghuysen

Acting President

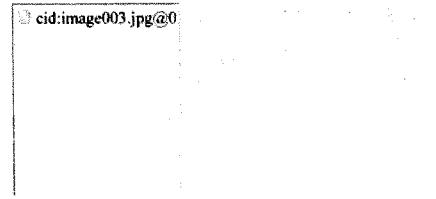
AFGE Local 0007 AFL-CIO

VA Medical Center

Tomah, WI 54660

Office: 608-372-3878

[REDACTED]



(1)

Ellinghuysen, Linda

From: Ellinghuysen, Linda
Sent: Thursday, October 09, 2014 6:29 PM
To: Dechant, David P.
Cc: Hensley, Lori
Subject: Temporary Office Move

Dave,

I informed Ryan Honi this evening of your call of later this afternoon and your message, which was to be passed on to him.

I informed Ryan of the following:

1. He is temporarily reassigned to the 406/Midway Office during the Investigation;
2. * After the Investigation, it will be decided if he will stay in the hired position or if he will be relocated in a like-position;
3. That he will continue to perform work for the ML SL (told him Lisa Noe or Dr. Skripka will give him assignments -- you didn't say that today, however that was discussed and agreed upon yesterday at our 2:00p.m. meeting.);
4. That you will get him a key to the 406 Office ASAP;
5. Since he starts at 7:30am and he doesn't have a key as yet, I asked Ryan to come to the Union Office tomorrow at 7:30am; and, close to 8:00am he can go over to 406 Office. I made arrangements with Dan Hannan to open up the 406 Office before/at 8:00a.m.

*In reference to #2, above.. In the meeting yesterday with you, Dr. Skripka, and Lisa Noe -- You stated that you were going to "work to find a like-position" for Ryan, which meant to the Labor attendees and to Ryan that he would not be going back to the MH Suite of Offices to work. There was nothing stated yesterday that where Ryan Honi works is dependent on the outcome of the Investigation. Ryan brought up this fact to me; I looked at my notes; and, my notes state that you stated that you were going to "work to find a like-position."

NOTE: For a "like position," there is the Unit Coordinator opening on 404, 3rd floor, which is vacant due to retirement of vice Mary ?. Ryan Honi would be working with clinical staff and closer with Veterans, which he would enjoy.

NOTE: The 406 Office is unsafe. Once the door is closed on a person, they cannot exit the office. If there is a fire, the person would have to break the glass window to escape. Jeff Evanson, SLM, presented at the 406 Office today at about 3:55pm and was made aware of this fact. Therefore, it is very important that Ryan be given a key so that he can exit the office to use the restroom and to go to breaks.

Thank you.
~ Lin.

Lin Ellinghuysen
Acting President
AFGE Local 5507 AFL-CIO
VA Medical Center
Tomah, WI 54660
Office: 608-372-3878
[REDACTED]

Hensley, Lori

From: Hensley, Lori
Sent: Thursday, October 02, 2014 10:40 AM
To: McDonald, Bob
Cc: Gibson, Sloan; Bevins, Debi; Ellinghuysen, Linda; Hannan, Daniel P.
Subject: FW: DC Office of Special Counsel Call
Signed By: lori.hensley@va.gov

Importance: High

Tracking:	Recipient	Delivery	Read
	McDonald, Bob	Delivered: 10/2/2014 10:40 AM	Read: 10/2/2014 10:50 AM
	Gibson, Sloan	Delivered: 10/2/2014 10:40 AM	Read: 10/2/2014 11:06 AM
	Bevins, Debi	Delivered: 10/2/2014 10:40 AM	Read: 10/2/2014 10:53 AM
	Ellinghuysen, Linda	Delivered: 10/2/2014 10:40 AM	
	Hannan, Daniel P.	Delivered: 10/2/2014 10:40 AM	

Dear Mr. Bob McDonald,

Ryan is not being treated as well as he should be. He is taken out of his work assignments that would allow him to see or print evidence to prove some of what he is whistleblowing about. He is taken out of his timekeeper duties and I have lost some of my access to nursing time scheduling program called AcuStaff. There should be someone far outside the Facility and VISN Leadership that should be doing the questioning of Ryan and the employees that know information. Too much gets covered up and the truth does not come out. You need to know this truth without it being covered up and passed off as miscommunication or another excuse.

My heart went out for Mr. Shinseki as he was not made aware of many of the things that transpires because first the VA facilities try to cover things from the VISN Leadership then the VISN may not share everything they should with Central Office. I beg you to stop this fact finding being addressed beginning today, possibly an hour or less from now by the VISN and have someone higher up the chain of command to investigate this like the Office of Special Counsel or a higher level DIG outside of the VISN/Region. Please consider this for Ryan, other VA employees whom some are also Veterans and the Veterans we serve who have served our Country and deserve exceptional care. I am the current Chief Steward of AFGE union, however, I am also an RN who has worked at this facility for 30 years as an RN and some of that time has been in Performance Improvement with close interaction with the Quadrad members. All the men in my extended family were Veterans including my husband's side of the family. This is a small facility to correct and show the other VA facilities that they had better adhere to your orders. There is so much to say and very little time to communicate. There are many of us at the facility who are fearful of retaliation and need Whistleblower protection. Look at the turnover rate at our facility of good professional employees and our employee satisfaction scores. Our top leadership needs to be evaluated closely. Please help all of us including the Veterans.

Thank you and know that this will also protect yourself. : McDonald, Bob
 Cc: Gibson, Sloan; Olson, James J.; Brown, Kathryn; Hannan, Daniel P.; Ellinghuysen, Linda;
 Hensley, Lori; Bevins, Debi
 Subject: RE: Follow up on voicemail

Sincerely,
 Lori Hensley

<u>Before Reporting Wrongdoing</u>	Just tries to do the right thing but my life is turned upside down	<u>After Reporting Wrongdoing</u>
① physically worked in service line.	① physically moved out of service line to 3rd floor across from HR	
② had a key for my office	② not given a key to have to go to my new office after asking people outside repeatedly for one my service line to have access	
③ answered phones for the service line	③ no longer able to answer phone for service line	
④ performed timekeeper duties	④ no longer allowed to perform timekeeper duties	
⑤ allowed to move about the facility w/o checking with service line, actions manager like other employees on the service line.	⑤ told that with the exception of going to the bathroom need to check with service line manager before leaving office. Was later told after repeatedly asking that I could use the restroom and go to the service line, but still have to report where I'm going	

Before

» After

→ the facility to act
service line manager
Don't → unlike other service line
think
It's from
Dr. Skripko to move about the
Never facility to perform their
put restriction duties
on me before

Received phone calls
from all MH staff when
they can't report to
work in the morning
so I could forward the
email that info to
VHATON MH Morning Huddle

No longer able to
accomplish that duty

Could print documents
and walk 15 feet to
the copier.

Am printing documents through
Jian Olson, going down to
get them and route from
the service line. This is
a hindrance to Jian and
a big waste of time
having to go 3 flights of
stairs for simple duties

Before

No shame

After

embarrassing that my
office is restricted
and people are wondering
why I was moved out
Makes me look guilty.
"Why me up here?"
Can't say why - people
are talking about what
is happening w/ me



DEPARTMENT OF VETERANS AFFAIRS
VA Great Lakes Health Care System
500 E. Veterans Street
Tomah, WI 54660

October 14, 2014

TO Human Resource Officer (05)
FROM: Ryan Honl, GS-5, Mental Health Secretary
SUBJ: Resignation Effective Tuesday, October 14, 2014

To Whom This Concerns

I am Resigning from the position of GS-5 Mental Health Secretary effective today.
Tuesday, October 14, 2014

This Resignation is a result of management's consistent and blatant Reprisal against me for my Whistleblowing protected activities. Even though I have received Whistleblower Protection from the Office of Special Counsel, Washington, D.C., management as well as two (2) co-workers have repeatedly harassed me and created a hostile work environment.

As a Veteran myself, I very much wanted to work at the Tomah, WI Veterans Administration; however, I can no longer work here as I find the working conditions intolerable. I have experienced a work area filled with hostility, which grew in intensity after I informed internal and external management about practices at this facility which consistently result in waste, fraud and abuse.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "Ryan Honl".

Ryan Honl

Retaliation AFTER resigning

- 1) Medical Records Access after I resigned. No explanation ever received about the reasons for each person accessing.
- 2) David Houlihan Threat to Sue raising the issue of my mental health
- 3) Police Report fabricated 4 months AFTER resigning and while VA inspectors at Tomah VA



DEPARTMENT OF VETERANS AFFAIRS
 VA Great Lakes Health Care System
 500 E. Veterans Street
 Tomah, WI 54660

November 4, 2014

In Reply Refer To: 001-PO

Mr. Ryan Honl
 414 Williams Street
 Tomah, WI 54660

Dear Mr. Honl:

This letter is in response to your request dated October 29, 2014 to restrict the use or disclosure of your individually-identifiable health information to the Tomah VA Medical Center facility.

At this time VHA is unable to grant your request for a restriction pursuant to 45 CFR 164.522(a)(1)(ii). VHA is not required to agree to your restriction request.

Please understand that the Veterans Health Administration (VHA) is bound by Federal Privacy Law and fully protects every veteran's health information from unauthorized disclosure. In general, VHA must have your written authorization to use and disclose your health information.

In accordance with the Privacy Act and HIPAA Privacy Rule, VHA may use and disclose your health information without your permission to provide treatment to you, to receive payment for health care services provided to you, for health care operation purposes and for purposes required by law. A copy of our VHA Notice of Privacy Practices is enclosed. I have also enclosed your Sensitive Patient Access Report (SPAR) dated July 1, 2014 to October 29, 2014 per your request. A review was conducted and those that have accessed your record did so for treatment, payment or other health care operation purposes.

If you should have any further questions in regards to your request, please contact Julie Sherman, Privacy Officer of Tomah VA Medical Center at 608-372-3971 Extension 66732 or at 500 East Veterans Street Tomah, WI 54660 (PO-001).

Sincerely,

Mario V. DeSanctis, FACHE
 Medical Center Director

Enclosure

Honl Ryan_3rd record of access
 DEVICE: HOME// Linux Telnet/SSH Right Margin: 80//

Sensitive Patient Access Report for FEB 29,2012 to NOV 25,2014 Page: 1
 Run Date : NOV 25, 2014@09:36 Social Sec Num: _____
 Patient Name: HONL,RYAN ALLAN Date of Birth : _____

USER	DATE ACCESSED	OPTION/PROTOCOL USED	INPATIENT
DETTLER,DAVID A RPH	AUG 11, 2014@11:16	Patient Prescription	NO
DETTLER,DAVID A RPH	AUG 11, 2014@11:15:30	Patient Prescription	NO
DETTLER,DAVID A RPH	AUG 11, 2014@11:15:20	Patient Prescription	NO
DETTLER,DAVID A RPH	AUG 11, 2014@11:15:10	Complete Orders from	NO
DETTLER,DAVID A RPH	AUG 11, 2014@11:15	Complete Orders from	NO
BENZING,RUTH A	OCT 29, 2014@08:30:10	View Registration Da	NO
BENZING,RUTH A	OCT 29, 2014@08:30	Patient Inquiry	NO
BENZING,RUTH A	OCT 29, 2014@08:27	Patient Inquiry	NO
BENZING,RUTH A	OCT 29, 2014@08:23	CPRSChart version 1.	NO
MESSING	NOV 09, 2014@10:48:10	CPRSChart version 1.	NO
MESSING	NOV 09, 2014@10:48	CPRSChart version 1.	NO
MESSING	OCT 30, 2014@18:59:10	CPRSChart version 1.	NO
MESSING	OCT 30, 2014@18:59	CPRSChart version 1.	NO

Sensitive Patient Access Report for FEB 29,2012 to NOV 25,2014 Page: 2
 Run Date : NOV 25, 2014@09:36 Social Sec Num: _____
 Patient Name: HONL,RYAN ALLAN Date of Birth : _____

USER	DATE ACCESSED	OPTION/PROTOCOL USED	INPATIENT
BAUERLE,SUSAN M	JUL 10, 2014@10:10	Order/test status	NO
WORZALLA,TAMELA L	OCT 29, 2014@10:47	CPRSChart version 1.	NO
WORZALLA,TAMELA L	OCT 29, 2014@08:45	Patient Profile MAS	NO
WORZALLA,TAMELA L	OCT 29, 2014@08:42	CPRSChart version 1.	NO
WORZALLA,TAMELA L	OCT 29, 2014@08:41:10	View Registration Da	NO
WORZALLA,TAMELA L	OCT 29, 2014@08:41	Appointment Manageme	NO
BRAND,DEANNE M	OCT 14, 2014@10:41	Load/Edit Patient Da	NO
BRAND,DEANNE M	AUG 19, 2014@08:42	Change Patient	NO
BRAND,DEANNE M	JUL 10, 2014@10:24	Change Patient	NO
BRAND,DEANNE M	JUL 10, 2014@10:04:10	CPRSChart version 1.	NO
BRAND,DEANNE M	JUL 10, 2014@10:04	Appointment Manageme	NO
BRAND,DEANNE M	JUL 07, 2014@16:23	CPRSChart version 1.	NO
BRAND,DEANNE M	JUL 07, 2014@16:22:10	Appointment Manageme	NO

Sensitive Patient Access Report for FEB 29,2012 to NOV 25,2014 Page: 3
 Run Date : NOV 25, 2014@09:36 Social Sec Num: _____
 Patient Name: HONL,RYAN ALLAN Date of Birth : _____

USER	DATE ACCESSED	OPTION/PROTOCOL USED	INPATIENT
BRAND,DEANNE M	JUL 07, 2014@16:22	Load/Edit Patient Da	NO
DEAN,KENNETH A	AUG 12, 2014@11:53	Register a Patient	NO
DEAN,KENNETH A	AUG 12, 2014@11:52	View Registration Da	NO
DEAN,KENNETH A	AUG 12, 2014@11:48	View Registration Da	NO
DEAN,KENNETH A	AUG 12, 2014@11:47	View Registration Da	NO
SENN,NICOLE E	JUL 10, 2014@15:35:10	Correct Incomplete E	NO
SENN,NICOLE E	JUL 10, 2014@15:35	Load/Edit Patient Da	NO

Honl Ryan_3rd record of access

BELL,LISA M	OCT 14, 2014@11:16	Patient Inquiry	NO
BRUEGGEN,SARAH A	OCT 16, 2014@07:34	Register a Patient	NO
CLAY,CYNTHIA M RN	AUG 19, 2014@13:57	CPRSGchart version 1.	NO
CLAY,CYNTHIA M RN	AUG 19, 2014@13:17	Integrated Billing 1	NO
CLAY,CYNTHIA M RN	AUG 19, 2014@13:11	CPRSGchart version 1.	NO
CLAY,CYNTHIA M RN	AUG 12, 2014@15:14	CPRSGchart version 1.	NO

Sensitive Patient Access Report for FEB 29,2012 to NOV 25,2014 Page: 4

Run Date : NOV 25, 2014@09:36 Social Sec Num:
Patient Name: HONL,RYAN ALLAN Date of Birth :

USER	DATE ACCESSED	OPTION/PROTOCOL USED	INPATIENT
CLAY,CYNTHIA M RN	JUL 18, 2014@08:07	CPRSGchart version 1.	NO
CLAY,CYNTHIA M RN	JUL 17, 2014@13:40	CPRSGchart version 1.	NO
CLAY,CYNTHIA M RN	JUL 10, 2014@11:21	CPRSGchart version 1.	NO
KELLY,KELLI J RN	AUG 11, 2014@09:26	CPRSGchart version 1.	NO
KROK,DARLENE A	AUG 11, 2014@11:06:10	Complete Orders from	NO
KROK,DARLENE A	AUG 11, 2014@11:06	Complete Orders from	NO
VAN AUKEN,WMILLIAM A	JUL 23, 2014@09:55	Patient Inquiry	NO
ZONDAG,TUENIS D MD	AUG 11, 2014@10:06	CPRSGchart version 1.	NO
ZONDAG,TUENIS D MD	JUL 16, 2014@07:14	CPRSGchart version 1.	NO
ZONDAG,TUENIS D MD	JUL 15, 2014@18:12	CPRSGchart version 1.	NO
ZONDAG,TUENIS D MD	JUL 14, 2014@18:55	CPRSGchart version 1.	NO
ZONDAG,TUENIS D MD	JUL 10, 2014@12:51	CPRSGchart version 1.	NO
ZONDAG,TUENIS D MD	JUL 07, 2014@18:50	CPRSGchart version 1.	NO

Sensitive Patient Access Report for FEB 29,2012 to NOV 25,2014 Page: 5

Run Date : NOV 25, 2014@09:36 Social Sec Num:
Patient Name: HONL,RYAN ALLAN Date of Birth :

USER	DATE ACCESSED	OPTION/PROTOCOL USED	INPATIENT
JOHNSON,DEBORAH J	OCT 30, 2014@09:42	Patient Inquiry	NO
JOHNSON,DEBORAH J	JUL 23, 2014@15:44	CPRSGchart version 1.	NO
KYLLONEN,DARYL T	AUG 12, 2014@21:29	Appointment Manageme	NO
KYLLONEN,DARYL T	AUG 12, 2014@21:28	Appointment Manageme	NO
KYLLONEN,DARYL T	AUG 12, 2014@21:27	Register a Patient	NO
LINDSEY,MISHELLE I	SEP 12, 2014@09:17	Patient Prescription	NO
LINDSEY,MISHELLE I	SEP 12, 2014@09:16:20	Patient Prescription	NO
LINDSEY,MISHELLE I	SEP 12, 2014@09:16:10	Patient Prescription	NO
LINDSEY,MISHELLE I	SEP 12, 2014@09:16	Patient Prescription	NO

Select Security Officer Menu Option:

Print

<https://us-mlg6.mail.yahoo.com/neo/launch?rand=89mukvor039tre84>

Subject: Need some help here
From: RAH (ryanahoni@yahoo.com)
To: jyoung@osc.gov; sarmitran@osc.gov
Date: Wednesday, October 29, 2014 9:39 AM

John,

I just got a VERY strange call from the Tomah VA. The woman, Tammy Warzella, said that I had submitted a complaint to Secretary McDonald from the Tomah VA phone line within the mental health unit complaining that I was having problems getting my medication. When Tammy saw the complaint went straight to Secretary McDonald from WITHIN the facility, she of course called me to follow up on the complaints. It of course wasn't me since I haven't even been to the hospital since I left and I get my VA meds from my hospital in Indiana (I'm a disabled vet with PTSD). I had shared with my supervisor, Lisa Noe, when I started, that I have PTSD and get care in Indiana, so I'm very concerned that since Dr. Skripka has been asking around to my former coworkers about my "emotional state" that someone used that as a pretext to go into my VA medical records. It is of course illegal due to HIPAA for anyone other than my doctors in Indiana to go into my medical records. Now I'm very concerned that someone is digging into the details of my medical history at the Tomah VA in order to discredit me as a whistleblower (I'm emotionally unstable, etc). Is there a way you guys can dig into this and find out what is going on? Since VA med records are electronic now, a history of those who have accessed my records are available, but I don't want to approach the facility here about it since Leah Finch, the current Privacy Officer, was the one who went into the evidence files that were locked in evidence in order to "explain away" the loss of files (see my QSC complaint).

It is certainly suspicious at the VERY LEAST as to why someone from within the Tomah facility would fraudulently submit a complaint from within the mental health unit at the facility when I don't even get my care there. For obvious reasons, I get my care in Indiana where I moved from. And then to throw in that the complaint went directly to Secretary McDonald is weird as well.

Not sure who else I could go to about this, but obviously someone is using my name within the Tomah facility to go into my VA med records. I have my suspicions as to why.

Ryan



HALE SKEMP
ATTORNEYS & COUNSELORS AT LAW

January 30, 2015

Ryan Hont

414 Williams St.
Tomah, WI 54660

Re: Demand for Retraction Pursuant to Wisconsin Statutes Sec. 895.05

Dear Mr. Hont:

My law firm represents David Houlihan. You have recently taken to defaming Dr. Houlihan on-line and in your comments made to reporters. This letter demands retraction of your most egregious false statements about my client. While I do not need to give you the opportunity to retract your statements under the statute, I am nonetheless giving you the opportunity to do so in an effort to limit your continuing liability.

The fact that I have not addressed every nonsensical statement you have made about my client does not make those other statements true. It just means that I do not have the time or patience to sort through all of your drivel.

You posted comments on www.disabledveterans.org. In the comments, you verified that you raised accusations against my client concerning care and treatment he provided to his patients at the Tomah VA Medical Center. Additionally, you wrote:

January 22, 2015:

It's not about taking away pain medication. It's about taking it away from the Houlihans out there that put a Marine like Jason Simcacoski [sic] on 14 powerful drugs and then a 15th one that killed him. So before Houlihan's addicts sing his praises, just remember Jason Simcacoski and the trail of destruction a man like David Houlihan leaves behind. Of course there are patients out there that love the Candy Man. He takes away their pain until it kills them.

On January 13, 2015, you wrote:

It is a travesty that one of the Veterans who died in the article was on 14 meds. some narcotics, and then put on a 15th one which resulted in "mixed drug toxicity" as stated in the University of Wisconsin autopsy report.

308 King Street
King City, WI 54632, Phone 608-784-3341
PO Box 1827
18 Chippewa, WI 54632-1827

Phone: (608) 784-3341
Fax: (608) 784-7414
www.haleskemp.com
e-mail: info@haleskemp.com

Page 2
January 30, 2015

These statements are completely false, defamatory and have caused damage to my client. Therefore, I am demanding immediate retraction of the same.

First, there is nothing in the autopsy report that shows that the "15th" medication prescribed to the Veteran was the cause of "mixed drug toxicity". According to the reporter that you have managed to get involved in this alleged controversy, Dr. Houlihan was not the Veteran's doctor. At most, according to *The Center for Investigative Reporting* article, Dr. Houlihan was consulted about putting the patient on Suboxone. The fact that Suboxone is used to treat opiate addiction is directly contrary to the professed motivation for your crusade and claims that my client prescribed opiates without any concern for the patients' welfare. Moreover, there is no correlation between Suboxone and this patient's unfortunate death. Finally, it is untrue that my client prescribed any medications to this individual or that he has left a trail of destruction.

Further, you have recorded video statements concerning my client, which were posted on www.wausaudailyherald.com on January 27, 2015. Every statement made by you in that video about my client is false and defamatory. My client hereby demands immediate retraction of the entire statement, specifically including the following:

1. "Jason Simcakoski who died of a mixed drug toxicity former Manne and I am here for him. Because what David Houlihan and the folks under his direction in this facility did to him um, resulting in his death you know needs to be transparent to the public." Mr Simcakoski was not Dr. Houlihan's patient and there are no facts that anything Dr. Houlihan did or did not do resulted in his death.
2. "Dr. Chris Kirkpatrick who 5 years ago David Houlihan ran out of his facility and he went home after he was terminated and put a rifle under his chin and blew his brains out." Dr. Houlihan did not "run" him out of the facility or otherwise play an active role in the termination of Dr. Kirkpatrick's employment. My client has no relationship to Dr. Kirkpatrick's alleged decision to take his own life.
3. "The VA is going to 'investigate itself about the crimes and unethical activities in the Tomah VA, um you know, for under the direction of David Houlihan.' It is patently false that any crimes or unethical activities have been committed under the direction of my client.
4. "[K]ids across Wisconsin that are being sold VA narcotics by patients who aren't taking the narcotics that David Houlihan has prescribed." This statement is entirely false and has no factual basis or support. There is no evidence that any Tomah VA patient is selling narcotics prescribed by my client to children- or to anyone else for that matter.
5. "[I]t's resulted in the death of Jason Simcakoski and it's resulted in the death of Chris Kirkpatrick and God knows how many others. Not just deaths but destroyed lives

Page 3
January 30, 2015

of good doctors, good nurses, good pharmacists, good administrators in this facility that have been run out because they do, they simply question why David Houlihan is doping up their patients so they can't even sit there and have a counseling session with them." My client has not retaliated against any VA employee for asking questions, he has not caused "deaths", "destroyed lives" or "doped up" patients so they cannot sit and have a counseling session.

My client demands an immediate retraction of your defamatory statements identified above. My firm continues to investigate other statements made by you to determine whether they are actionable and reserves the right to demand further retractions from you.

As a Veteran myself, I believe that you are doing a disservice to our Veterans by targeting a doctor that has done nothing wrong and puts proper and appropriate care of his patients above all else. While you have the right to express your opinions regarding the need to improve Veteran care in our country, this does not give you license to defame people such as my client.

I am told that you have invited me to sue you on your Facebook page. You will likely get your wish. I am also told that you believe such a lawsuit would be "whistle blower retaliation." If this is your belief, you obviously have little understanding of the law. Being an alleged whistle blower, by filing a bogus complaint asserting third hand allegations against my client in a weak effort to blame others for your shortcomings in trying to perform a simple job consisting primarily of answering phones and putting papers into files, does not in any way protect you from civil liability for defaming my client.

Thank you for your attention to this matter and I look forward to receiving your notice that you have publicly retracted your defamatory statements.

Respectfully,

HALE, SKEMP, HANSON, SKEMP & SLEIK

By: Francis (Frank) M. Doherty
e-mail: fmd@haleskemp.com
FMD/as

Print

<https://us-mg6.mail.yahoo.com/neo/launch?.rand=0qfh1g4ts00aa5333...>

①

Subject: Fwd: Tomah VA Phone Message
From: Daniel Bice (dbice@jrn.com)
To: ryanahonl@yahoo.com
Date: Saturday, February 7, 2015 7:11 PM

Here you go.

Sent from my iPhone

Begin forwarded message:

From: Frank Doherty <FMD@haleskemp.com>
Date: February 6, 2015 at 4:59:24 PM CST
To: 'Daniel Bice' <dbice@jrn.com>
Subject: RE: Tomah VA Phone Message

Dan,

Below are my answers:

1. How long have you been working for Dr. Houlihan? I thought he had another attorney.

I have been representing Dr. Houlihan since mid-January, shortly after the first defamatory statements about him were published.

2. How quickly do you expect to sue Mr. Honl if he doesn't retract his remarks?

Wisconsin's statute of limitations for defamation claims is three years and no timetable has been set for filing suit as Dr. Houlihan hopes that Mr. Honl will publicly retract his false statements about Dr. Houlihan.

3. Mr. Honl said he is a minimum-wage worker with no assets. If true, why would Dr. Houlihan sue him?

Dr. Houlihan has no particular desire to sue Mr. Honl, whom, according to his blog posts, is a disabled veteran discharged from the service due to mental health issues. However, Dr. Houlihan must protect his reputation from the false statements that have been made about him as a physician. My firm's investigation of this matter has lead me to the conclusion that the attacks on Dr. Houlihan are being orchestrated by the local union, which is more interested in protecting employees that perform poorly.

why does Frank Doherty reference my "mental health issues?"

Print

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than they are interested in ensuring that the VA provides the best possible care to our Veterans. Unfortunately for Mr. Honl, he appears to be left holding the bag for others and is unwittingly working against his stated interest in improving healthcare for Veterans.

4. Does Dr. Houlihan have any response to the statements by the state Department of Safety and Professional Services that it is investigating him?

My understanding is that the State investigates all complaints made against a doctor. If any formal investigation is conducted by the State, Dr. Houlihan will fully cooperate with the investigation and will be cleared of any alleged wrongdoing, just as the VA cleared Dr. Houlihan of 32 mostly anonymous allegations after a two year comprehensive investigation.

Frank Doherty

Hale, Skemp, Hanson, Skemp & Sleik

505 King Street, Suite 300

La Crosse, WI 54601

608-784-3540

fnd@haleskemp.com



***** Email confidentiality notice *****

This message is private and confidential. If you have received this message in error, please notify us and remove it from your system.

From: Daniel Bice [mailto:dbice@jim.com]
Sent: Friday, February 06, 2015 2:32 PM
To: Frank Doherty
Subject: Re: Tomah VA Phone Message

Here are my questions:

2 of 4

2/22/2015 2:18 PM

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(3)

1. How long have you been working for Dr. Houlihan? I thought he had another attorney.

2. How quickly do you expect to sue Mr. Honi if he doesn't retract his remarks?

3. Mr. Honi said he is a minimum-wage worker with no assets. If true, why would Dr. Houlihan sue him?

4. Does Dr. Houlihan have any response to the statements by the state Department of Safety and Professional Services that it is investigating him?

I think that's it. If you have anything else to say, feel free to share your thoughts.

Thanks.

Dan Bice

On Fri, Feb 6, 2015 at 2:26 PM, Frank Doherty <FMD@haleskemp.com> wrote:

Dan,

I received your voicemail. What specific questions did you have?

Frank Doherty

- husband of one of David Houlihan's subordinates

Hale, Skemp, Hanson, Skemp & Sleik

505 King Street, Suite 300

La Crosse, WI 54601

608-784-3540

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Subject: Fw: Police Report on Me by the Tomah VAMC PD

From: RAH (ryanahoni@yahoo.com)

To: meghan.serwin@va.gov; robert.a.mcdonald@va.gov;

Cc: brian.downey@hsgac.senate.gov; bill.murat@baldwin.senate.gov; diana.maas@mail.house.gov; debi.bevins@va.gov;

Bcc:**Date:** Friday, February 13, 2015 9:37 AM

Bob/Meghan,

Couple things here. The below is self explanatory. Black and white. Given that Carolyn Clancy's team couldn't investigate their way out of a paper bag, I'm hoping the VA Office of Accountability can see this for what it is. If not, then there is no hope for VA accountability within the VA. Why is Clancy's investigative team coming to Tomah to have "selected" interviews with staff they pick to talk to and at a time when the union leadership is in DC?

Also, regardless of how I obtained my police report that's attached, I don't appreciate Mario Desantis through Police Chief Huffman going on a witch hunt on whistleblowers in the facility to find out who anonymously leaked it to me. And as far me having this police report, it sure is nice to be able to see it. It is about me after all, yet conveniently hidden from me or anyone else that can hold these clowns in Tomah accountable. Also at a time when Clancy's investigators are at the facility. I'm sure THEY have a copy.

When will the VA hold people accountable at the Tomah VA? Does it have the ability? So far it hasn't shown it. Why did one of Clancy's staffers tell me I could only have 3 minutes to meet with her as long as I "didn't make a scene?" then wouldn't see me at my request in the union building for any length of time. Was that another PTSD symptom used against me at a time when a sham police report on me was surely given to them?

Bob, I know you're kept in the dark by Griffin at the VA OIG who hides reports like the Tomah sham "investigation." I know you don't have the power to fire Griffin. Only the President does. But when you are presented with something like this in black and white, will something be done? Will you hold Tomah leadership accountable when presented with facts like this? Will you order them to cease their witch hunt over it? These failed leaders in Tomah would spend their time and tax money in a better fashion cleaning up the facility rather than those who raise

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concerns over me getting railroaded. But of course, the entire leadership IS the problem after 10 years of David Houlihan stocking the place with his loyalists. Will you do something about this? The public and the media aren't standing for it.

Ryan

cc:
 Senator Johnson
 Senator Baldwin
 Representative Kind

bcc:
 Media
 Whistleblowers
 Concerned Citizens

----- Forwarded Message -----

From: RAH <ryanahoni@yahoo.com>
To: Rush <arush@osc.gov>
Cc: Downey, Brian (HSGAC) <brian_downey@hsgac.senate.gov>; Diana Maas <diana.maas@mail.house.gov>; Bill Murat <bill_murat@baldwin.senate.gov>
Sent: Thursday, February 12, 2015 1:14 PM
Subject: Police Report on Me by the Tomah VAMC PD

Angie,

Attached is clearly a sad attempt at discrediting me post fact. Please add to my OSC case file. Police report on me filed Feb 2, 2015, nearly a month after things hit the press and 4 months after I resigned and interestingly enough in the middle of VA inspectors coming to "investigate" the Tomah facility in February 2015. I received this from someone anonymously within the facility who was kind enough to bring it to my attention. Considering my diagnoses are well known in the facility due to 5 people fraudulently accessing my medical records in October 2014, the terms used are all symptoms of PTSD.

Terms such as:

"agitated and verbally aggressive" - Leesha Dukes
 "red in the face and shaking" - Leesha Dukes
 "irrational" - Leesha Dukes
 "he [Ryan] is not stable" - Leesha Dukes
 "face turned red and he began shaking" - Rachel Fleming
 "crazy" - I love that one from someone working in a mental health unit - Rachel Fleming
 "yelled" - Rachel Fleming
 "thought he [Ryan] was going to hit her [Rachel Fleming]" - Rachel Fleming
 "done at the request of Chief Huffman [Perry Huffman]" - investigating officer forced to do the report

These terms were used by people I reported, Rachel Fleming and Leesha Dukes, former coworkers that also reported into Lisa Noe, my former supervisor. Chief Perry Huffman is also

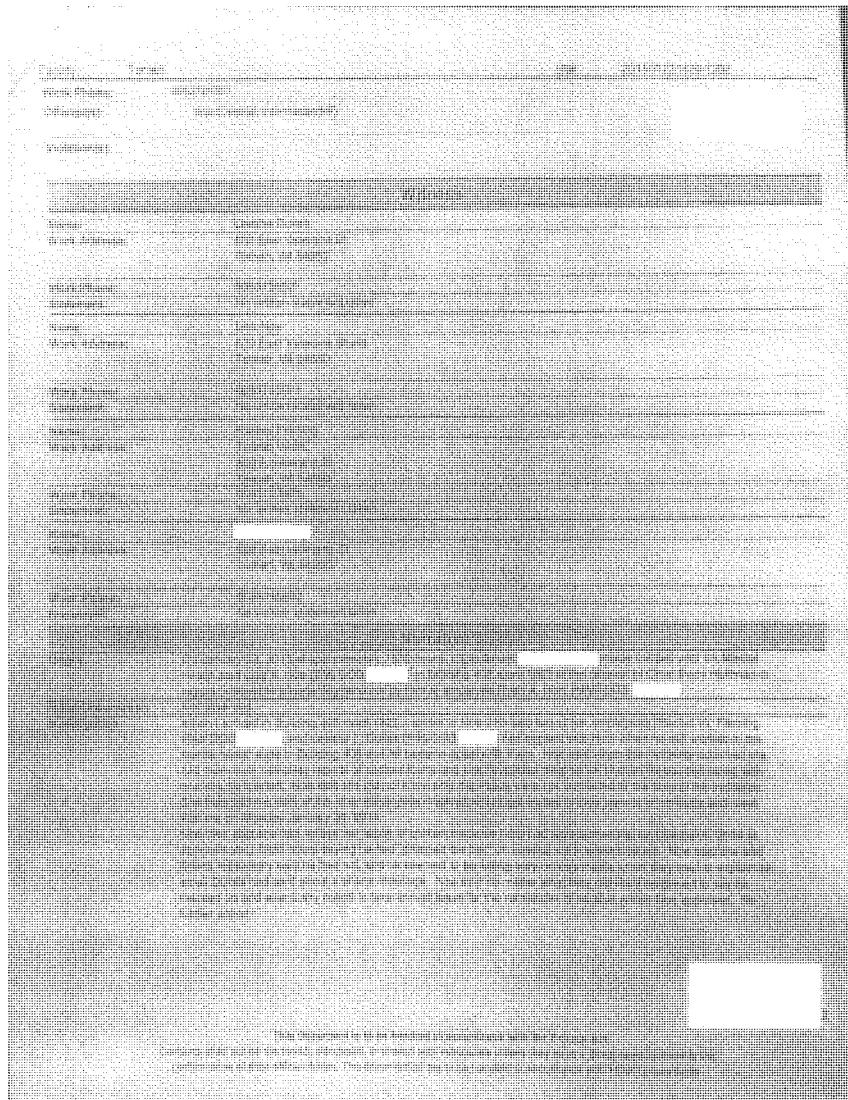
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From

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someone I reported after he got the VISN to close out one of my OIG allegations when missing files suddenly "reappeared." All well documented and provided to you at OSC.

The intent is clear. In the middle of VA inspectors "inspecting" the facility, this is a sad attempt at discrediting me post fact and now part of the public record. You'd think if I was such a "threatening" person, a police report would have been done during the time of the "incidents."



Investigating Officer:	Signature:
Address:	Date:
Printed By:	
1. End of Report	
Follow Up	
Investigator: SHELBY CAMPBELL Date/Times: 2/20/2014 9:17:17 AM	Initial contact with Building 403 Mental Health Officer, Lisa W. Fleming, at 10:00 AM on 2/20/2014 and approximately 1340 hours. (Interviewer: [REDACTED])
<p>In this report, initials in reference to this area:</p> <p>POLE DUCHESS (Lisa W. Fleming) - I first met with Pole in her office in Building 403 room 1025. Pole was seen on October 8, 2014 when I was meeting with Brian A. Farn (MSW DOB [REDACTED]) and she was helping to treat him and he became agitated and verbally aggressive, after one had been a couple of week hospital visits. Pole was also in the emails which were received as potential to have a very bad reaction to her care. Lisa W. [REDACTED] (MSW DOB [REDACTED]) to have a meeting with Brian A. Farn. Pole told Dukes what was necessary about that planning and she said he was treated and no "other" (anyone else's) input was had, which she believed to be the amount of the emails she had sent. I asked her to describe his behavior and she said he was not in the face and shouting and in a "raised voice" he told her he had only been working at the Veterans Affairs [REDACTED] Hospital for two days. Pole told me she believed this was very inappropriate and concerned that this the person who should not be a nurse. Pole was advised she is worried because she had a lot of time to amass sensitive information. I asked her if she had said that person was off the clock in any way and she said he was not.</p> <p>Pole's Office at the time I first contacted her from [REDACTED] and she said she did not and that was why she would not have called a behavioral interview. She then took a pause and commented she was not believeable either anyway. I then advised in the event of the day two days later to go to 11th floor was a behavioral button on the emergency device. I also told her if she had any other issues to let me know as soon as after that she should contact the VA Police and she would be seen. Pole said she had no other issues to contact her. Pole was also informed that she may have had personal communication issues if she was not able to do her job. I told her if that occurred she would need to contact her local Police Department and that VA Police (MSW DOB [REDACTED] DOB [REDACTED]) on 2/21/2014 at 10:00 AM to recall her and she never would one of which was believed to be the cause of the lack of behavior. She did not know what was going on and did not stay out to see.</p> <p>INTERVIEW WITH FLEMING: I first interviewed Fleming in Building 403 room 1024. Fleming met on September 23, 2014 at approximately 10:30 AM and met with [REDACTED] who was meeting the same time with a supposed association with [REDACTED]. Fleming stated when she informed him of what was going with the [REDACTED] he had written [REDACTED]. She told during that meeting [REDACTED] was not very nice and he began to complain. Fleming advised he had a "candy" jar but no [REDACTED] asked that she was very complimentary. At that point Fleming said she told him that she was leaving the work space and they would work together again later when he had cooled down. Fleming said they also spoke and she said he was going to fill her [REDACTED] with her and she thought he had a lot of [REDACTED] and she was going to fill her [REDACTED] with her and she was very upset. She then said he told her she did not know what was going on and she did not know what was going on. Fleming said she then returned to her office room 1024 and closed the door. Fleming said she then spoke to [REDACTED] who was directly across from her in Building 403 room 1024 and Fleming had been working. Fleming said [REDACTED] told her he did not hear or see anything. I then asked Fleming if [REDACTED] had at any point mentioned her as being off her job. I also requested her if she was in fact for her safety the [REDACTED] to activate the behavioral interview button in the [REDACTED] office which she and [REDACTED] were working on on 9/11. I was advised it was necessary a behavioral interview when she was starting or leaving her work space and going to her vehicle she could contact the VA Police. Fleming said she did not feel she would need it but was grateful to know it was an option.</p> <p>INTERVIEW WITH [REDACTED]: I first interviewed [REDACTED] in Building 403 room 1027. [REDACTED] said he did hear or see anything in regard to the behavioral interview because of the three people he informed him there was a lot of behavior in the office so it did not care but not care.</p> <p>By [REDACTED] [REDACTED]</p>	

Secretary Bob McDonald Emails

- 1) Resignation email
- 2) Concerns about criminal activity involving a patient death

From: ryanahonis@yahoo.com
 Subject: My farewell and final report on the Tomah VAMC
 To: robert.a.mcdonald@va.gov; steven.gibson@va.gov
 Cc: j@vso.gov; r@vso.gov
 Date: Tuesday, October 14, 2014 9:27 PM

Bob/Sarah (and others at OSC)

Integrity. The quality of being honest and having strong moral principles. I started at the VA two short months ago because the two men at the top are men of integrity. The measure of integrity is a person's actions. Bob, it was through your actions that I originally decided I'd give the VA a shot at employment after spending 15 years of my life giving excellent VA care from some of the brightest nurses and physicians I've ever known. They are living examples of what the VA is all about. They are the hands that touch our Veterans who have sacrificed mind and body for the rest of us. Soldiers don't spend much time asking why when told to go somewhere others wouldn't, they ask where and they go. And when they are disabled and needing care after their service, they again ask where they should go. The VA is that place. It is the final act that the nation bequests, must bequests, on those who have given mind and body. President Lincoln had it right.

Gentlemen, the current VA leadership has failed. The insular nature of VA management leads to a culture of intimidation on those who try to do the harder right rather than the easier wrong. What does a person do when asked to falsely incite & elevate those that do? I know that you know the answer to that. What does a person do that faces the question of whether or not to say something in the face of intimidation for raising legitimate concerns? Does that person stay quiet in the face of a leadership that intimidates and demoralizes those that raise concerns and force those out that raise them and leave neophytes and sycophants behind?

I will not and I cannot reveal the names of the nurses and doctors at the Tomah VAMC concerning the graveled issues at this facility. They feel intimidated and in fear of upper leadership. Past is prologue and they've seen far too many good people run out. The most immediate threat to patient health & safety in this facility are those who are either over prescribed narcotics which according to good doctors and nurses that came out of the woodwork to talk with me once they knew I rose issues publicly. There needs to be a complete, full, and impartial investigation of the Tomah VAMC. The most disheartening issue that the VA faces is an OIG that is part of the problem. You, Bob and Sarah, are not being well served. It is my conviction that with great certainty that leadership, especially now at least in VISN 12, is doing everything in its power to prevent any truth or raised issues concerning patient health & safety make it to you at the highest levels of leadership. I believe this is due mainly due to neophytes. No one at the ground level at Tomah VAMC has any faith whatsoever in the VISN 12 OIG conducting anything even close to an impartial investigation on the behalf of patients and staff. There have been deaths among psychiatric patients in this facility over the years that doctors and nurses are despondent over. When these concerns are brought forward anonymously, VISN 12 OIG comes in and does more to explain away incidents like these, rather than implement protocols to prevent such deaths.

I cannot stress enough that it is important for someone, whether at your leadership level or outside the VA, to come to Tomah VAMC to interview a wide swath of physicians and low level staff in order to get a sense of what I am talking about. When the OIG comes into the facility, they keep investigations as narrow as possible to avoid bringing out the deeper issues of what is happening at the facility. Again, this is mainly due to the neophytic nature between the facility and the VISN 12 leadership. In one particular case that I am a direct witness to concerning fraud with personnel files, Tomah VA Police Chief Hultman, fed an OIG complaint "on my behalf" with the VISN OIG in order to circumvent one aspect of my complaints. See the attached letter to see the key player in this unbelievably blatant misuse of authority. One of my complaints is that personnel records have been so utterly mismanaged that the leadership and staff in Tomah have no idea where some files are. By Chief Hultman getting the VISN to turn over the "investigation" of this case, Director DeSanctis directed the business.

Integrity Officer, Leah Finch, to break the seal on police evidence and explain away where the missing files were. Gentlemen, I am a direct witness to the loss of these files. Yet, now that the evidence has been tainted, it makes me look a fool.

Concerning my other complaints, I begin with the Chief of Staff, Dr. Houlahan. Although I didn't directly witness his misuse of narcotics with psychiatric patients, physicians and staff to the lowest levels are aware that he prescribing has, in their words "complicated" patients. When Dr. Murawsky called me on September 26, he acknowledged exactly what I had been hearing that Dr. Houlahan has been the target of several investigations concerning this behavior. Who ran the investigations into knocking down these allegations repeatedly? VISN 12 OIG. While saying farewell to several physicians today, I was made aware that at the last Chief of Staff meeting between Dr. Houlahan & all mental health physicians which took place after I brought my complaints forward, he stated to everyone that the "anonymous" allegations brought against him were not credible. He then turned over the management of approximately 40 patients to subordinate staff saying that it was now up to them to

1 of 3

manage the patients and deal with anonymous investigations. Again, there needs to be a full and impartial investigation into Dr. Houlahan's treatment of psychiatric patients, not from the VISN 12 level, but from a higher authority that is entirely impartial.

Concerning my complaint that my service line manager, Lisa Noe, left uncomfortable about marking Dr. Ronda Davis as present when she was AWOL from her day shift, and then later, after meeting with Dr. Houlahan, telling me "It's OK. You can record her as present for her shift," there is something to explain that away according to leadership. Dave Dechant, the HR supervisor, informed me and witnesses that Dr. Davis came in later that night to work her shift and that leadership was aware she would do that. This is blatantly false. Lisa Noe and Dr. David Skripka, Associate Chief of Staff, Mental Health, directed three of us to try to make contact with Dr. Davis at her personnel residence to no avail. How could leadership possibly say that they knew she wouldn't be in for her regular shift when they are asking the three of us to "find out where she's at"? Is it proper for a physician to show up for work whenever they feel like it especially when they are responsible for mental health patients in the inpatient ward? Why would Dr. Skripka be running around like a headless chicken covering those patients away from his Chief of Staff duties, telling the three of us to find out where Dr. Davis is, all the while having staff from the inpatient unit calling me to ask where she was? Out of fairness to Dr. Davis, although it was wrong to not show up that day for her day shift, she is overworked and being set up by management to take the fall for not getting everything done (patient notes, etc). Dr. Davis sent a message out to leadership on September 17 (the day after her absence) via email stating that she is overworked and needs support from management concerning more staff. I suspect the reason they didn't want to hit her with an AWOL charge is so that she wouldn't come forward publicly with her concerns over patient health & safety due to being short staffed and burned out. So what does management do? They go after her for not entering all of her patient notes so that when they do terminate her, they'll have a strong documentable case to get rid of her for that which will discredit her to preempt the far more concerning issues of patient health & safety taking place in building 403A, the mental health inpatient ward.

There are other complaints in my DIGOSC complaints, but these are the ones that directly affect patient health & safety. Although a case can certainly be made that patient health & safety are in danger when the hospital loses physician credentialing from lost files as well as fraudulently recording mandatory doctor educational courses "to make the reports look good" certainly has an effect on the health and safety of patients.

Now on to the retaliation I've experienced since coming forward. It's really too much to list without writing a book, but I'll highlight three here. One, the first week after reporting to you and the OIG, I was placed on the third floor in building 403 directly across from human resources, restricted to move anywhere in the facility unless I reported directly into the Associate Chief of Staff, Dr. Skripka. This is something my co-workers certainly did not need to do or even myself before the complaint. Two, I began to receive email after email from Leesha Dukes, administrative assistant to Dr. Skripka and Lisa Noe, copying both of them concerning many areas I had fallen short on in my duties. One morning, I received 5 emails from her within the first 45 minutes of my shift. I responded to Lisa Noe asking her whether or not I needed more training or exactly what I was falling short on in my duties. She stated, "Oh it's only information. Leesha is trying to help you." Any reasonable person looking at those actions would immediately see the retaliation. Three, Dr. Skripka has repeatedly referred to my "emotional health" when speaking with other people in the facility since my complaint. This is the most hurtful form of retaliation, trying to discredit me due to my "emotional health".

It is for these reasons that I tendered my resignation today. But more importantly, it was for the sake of my family and to avoid being set up as the fool. I wish I were a stronger person to withstand all of this retaliation, but I'm only human. I wish I could do it on behalf of the Veterans who are so ill-served at this facility because what I am leaving behind is just another reason not to raise issues.

The last thing I will leave you with is where I started out with this letter. There is an abhorrent failure of leadership at the Tomah VAMC that extends into VISN 12. Unless someone comes into this facility to interview every physician and staff member in an open and impartial way, OIG will simply continue to minimize any complaint or raised issue. Their goal, Bob and Sean, is to keep information concerning patient health and safety AWAY from you to cover for their failed leadership. I am aware that Dr. Mursawsky resigned as VISN 12 Director. One immediate thing you could do as senior VA leadership is to place someone into that position from outside the VA, preferably from the private sector, a person of integrity who will not be intimidated by those who don't serve their leadership well. Closer to home in Tomah, it is well known after several VISN 12 OIG investigations that Dr. Houlahan is at the center of much of the wrongdoing, but Director DeSanctis turns a blind eye and commits the sin of omission. Everything the public hears as well as higher VA leadership is that Tomah is a model within the VA system. If that were true, then why the activity I've witnessed as well as that witnessed by intimidated and demoralized staff? And is it a coincidence that Sharon Helman, the former director of the Phoenix VA embroiled in scandal, the former director of Hines VAMC in Chicago embroiled in scandal, rose through the ranks and learned her leadership "skills" at the Tomah VAMC? It could be a coincidence, but I am willing to say with integrity that due to the culture of corruption and intimidation at the Tomah VA, patient health and safety concerns have spread like a cancer even outside this facility.

Though I'm no longer a VA employee, I am always at your service, but more importantly, at the service of Veterans. Hopefully, though my time at the VA has been too short, in some small way I've brought light to issues that if ultimately fixed, will create better care for Veterans and fulfilling President Lincoln's promise, to care for those who have borne the battle.

Regards,

Ryan Hori
ryanahori@yahoo.com

Duty Honor, Country

Print

<https://us-mg6.mail.yahoo.com/neo/launch?.rand=0qfh1g4ts0aa#499...>

Subject: RE: [EXTERNAL] Criminal Activity
From: RAH (ryanahoni@yahoo.com)
To: Robert.A.McDonald@va.gov; Sloan.Gibson@va.gov;
Cc: debi.bevins@va.gov; meghan.serwin@va.gov;
Bcc: aglanz@cironline.org
Date: Saturday, November 29, 2014 11:12 PM

Bob,

Thank you. I hope you understand my reluctance to speak with anyone within the VA besides you and Sloan. The reasons are obvious. From initially raising concerns to my former service line manager, to facility leadership, to Jeff Murawsky, to a sham investigation of "facts" led by Ed Landreth at the VISN, and now to documents with John Daigh's signature covering up dozens of allegations within the Tomah facility in an OIG report referencing other reports not made publically available and probably not made available either to Secretary Shinseki or you. I'll talk to Megan, but realize that any discussions I have with her will be relayed externally to the VA at OSC. I and the others at Tomah as well as families of former employees who have raised these issues have talked to VA officials up and down the chain of command and they are fearful of taking anything more to the VA. I'm not questioning Meghan's integrity by any means, but I hope you see our concerns here. Trust but verify as has been said.

Ryan

Sent from Yahoo Mail for iPad

At Nov 29, 2014, 9:59:09 PM, McDonald, Bob<Robert.A.McDonald@va.gov> wrote:

Ryan, I have contacted Meghan Flanz, who is in charge of our Accountability Review Organization, and is an attorney. Thanks, Bob

-----Original Message-----
From: RAH [mailto:ryanahoni@yahoo.com]
Sent: Saturday, November 29, 2014 7:55 PM
To: McDonald, Bob; Gibson, Sloan
Cc: Bevins, Debi
Subject: [EXTERNAL] Criminal Activity

Bob,

1 of 2

2/22/2015 2:07 PM

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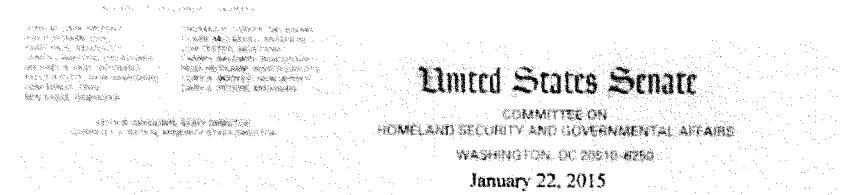
I have evidence of possible criminal activity after speaking with someone concerning a death. It is very important that you not speak with the OIG about this email I'm sending. I am concerned that John Daigh and VISN 12 leadership swept it under the rug, so few people are aware of it nothing has been done. You need to involve the FBI. Others are contacting the FBI, but since you obviously would have quicker access to them and also to proactively be on top of things, please contact them also from your end. I will speak with only the FBI concerning conversations I had this evening or any of the other documents I have. Dr. Houlihan is directly involved. This particularly involves people outside the VA which I will talk to the FBI about.

Ryan

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Senator Letters

- 1) Senator Johnson calling for a permanent VA Inspector General that doesn't hide reports
- 2) Senator Baldwin calling for a criminal investigation



Via Electronic Transmission

President Barack H. Obama
 The White House
 1600 Pennsylvania Avenue
 Washington, DC 20500

Dear Mr. President:

I write today regarding the urgent need for a permanent Inspector General to lead the U.S. Department of Veterans Affairs (VA), Office of Inspector General (OIG). During 2014, the country became aware of many problems that veterans encountered at VA medical facilities around the country. Most recently, troubling news at the Tomah VA medical center (VAMC) in Wisconsin underscores the need for you to nominate someone to serve in this important position.

The problems surrounding the Tomah VAMC have led veterans and VA employees to question not only the leadership at the facility but at the VA Office of Inspector General.

I recently became aware of a March 2014 VA Inspector General report centered on a variety of allegations at the Tomah VAMC.¹ Some of the findings were more than troubling. The rate of opioid prescriptions at Tomah VAMC was disturbing enough that issues were brought to the attention of VA leadership. It was also noted that Tomah VAMC ranked highest in the Veterans Integrated Service Networks (VISN) for the total morphine equivalents per unique patients treated with opioids. These issues must be fully investigated for the veterans who rely on this facility for their healthcare.

Further, my office, among others, never received a briefing or the March 2014 Tomah VAMC report from the VA Office of Inspector General. I am currently seeking an explanation from the VA's Deputy Inspector General.

The VA Office of Inspector General has gone far too long without a permanent Inspector General. Former VA Inspector General Opfer made known his intentions to leave the post in November 2013.² Now over a year later this post remains empty and that is unacceptable.

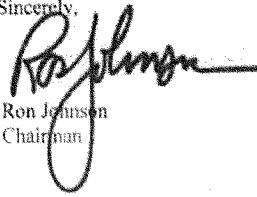
¹ U.S. Department of Veterans Affairs, Office of Inspector General, Administrative Closure: Alleged Inappropriate Prescribing of Controlled Substances and Alleged Abuse of Authority at the Tomah Medical Center, MCI# 2011-04212-HI-0267.

² VA Inspector General Opfer letter to President Obama, November 6, 2013. Accessed at: <http://www.va.gov/oig/2013/11/06/opf-letter.pdf>

I am hopeful that you along with the Council of the Inspectors General on Integrity and Efficiency (CIGIE) have narrowed down a list of candidates so we can work together to quickly fill this position.

Having a permanent Inspector General is necessary to root out waste, fraud, and abuse for the taxpayers and bring accountability for millions of veterans. I look forward to working with you to confirm a qualified individual to fill this important post.

Sincerely,

A handwritten signature in black ink, appearing to read "Ron Johnson".

Ron Johnson
Chairman

cc: The Honorable Thomas R. Carper
Ranking Member
Committee on Homeland Security and Governmental Affairs

TAMMY BALDWIN
WISCONSIN

United States Senate

WASHINGTON, DC 20510

COMMITTEES
APPROPRIATIONS
BUDGET
HEALTH, EDUCATION,
LABOR, AND PENSIONS
HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS

February 12, 2015

The Honorable Eric H. Holder, Jr.
Attorney General
U.S. Department of Justice
Office of the Attorney General
950 Pennsylvania Avenue, NW
Washington, D.C. 20530

Dear Attorney General Holder:

I am writing to request that the U.S. Department of Justice (DOJ) launch an immediate investigation into allegations of criminal wrongdoing at the Tomah Veterans Affairs Medical Center in Tomah, Wisconsin. I am extremely troubled about reports linking the tragic deaths of three Wisconsin veterans to improper medical care at the facility. Additionally, I have heard concerns regarding the conduct of the Tomah VA and the Tomah VA Police Department in response to the deaths that occurred at the facility. Finally, concerns regarding the illegal distribution and use of prescription drugs that originated at the Tomah VA facility have been raised. The U.S. Department of Veterans Affairs (VA) and its Office of Inspector General (OIG) are currently investigating a number of issues related to the Tomah VA, but I believe the seriousness of the allegations warrant an additional external and objective review by a law enforcement agency totally independent from the Department of Veterans Affairs. Accordingly, I request that you investigate both the circumstances surrounding patient deaths and allegations of the illicit distribution of opioids that originated at the Tomah VA facility.

At least three veterans—Jason Simcakoski, Thomas Patrick Baer and Jacob Ward—who were treated at the Tomah VA have tragically lost their lives. Below is information surrounding their tragic deaths.

1. Thomas P. Baer, 74, of Marshfield, Wisconsin, passed away in January at Gundersen Hospital in LaCrosse, Wisconsin. Prior to his arrival at Gundersen, Mr. Baer experienced very troubling treatment at the Tomah VA, including excessive wait times, broken medical equipment that was required for his treatment, and inadequate adherence to standard medical protocols.
2. Jason L. Simcakoski, 35, of Stevens Point, Wisconsin, passed away on August 30, 2014, at the Tomah VA. According to reports, Mr. Simcakoski, a former Marine, checked himself into the Tomah facility citing an addiction to opioid painkillers and severe anxiety. At the time of his death from "mixed drug toxicity," he reportedly was on 15

different prescription drugs, including anti-psychotics, tranquilizers, muscle relaxants, and opioid painkillers.

3. Jacob M. Ward, 27, of Milwaukee and formerly of Coon Valley, Wisconsin, passed away on September 4, 2013, at his home in Milwaukee. The Army veteran reportedly became addicted to opioid painkillers and other drugs after treatment for PTSD at the Tomah VA.

I would request that you conduct a full investigation of these three tragedies. In addition, I'm concerned about the treatment of other patients who may have died after receiving care at this facility. Therefore, I would encourage your review to not only include the three cases mentioned above, but also include any Tomah VA patient who died after receiving treatment at the facility. The investigation should include a review of both the administration of care and subsequent internal investigations.

Regarding the administration of care, please investigate, at a minimum, the following:

- The circumstances surrounding the deaths
- The medical treatment these patients received at the Tomah VA
- The Tomah VA's protocol for treating patients
- Inappropriate opioid prescribing practices
- Whistleblower retaliation
- Illegal access of confidential medical records
- Failure to maintain medical equipment
- Failure to comply with appropriate triage and medical treatment protocols

Regarding the internal investigations and conduct following the deaths, I would ask that you investigate, at a minimum, the following:

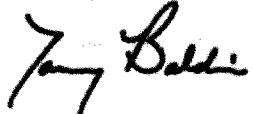
- The investigations conducted by any entity and specifically:
 - The Tomah VA's leadership
 - The Tomah VA Police Department
- The handling of internal facility and law enforcement records
- The accuracy and completeness of death investigation records and the preservation of evidence

In addition, concerns have been raised regarding drug diversion from the facility and the role this has played in illegal drug distribution and use in the area. Therefore, I would ask that you investigate the illegal distribution and use of drugs associated with the Tomah VA facility and the local Tomah area.

A broad and detailed investigation of the Tomah VA will provide much needed accountability and information that will help us improve the delivery of timely and highest-quality care to

veterans in Wisconsin and throughout the country. To achieve that goal, and in light of the severity of the allegations, I believe the law enforcement authorities, investigative expertise, and independence of the U.S. Department of Justice are required.

Sincerely,



Tammy Baldwin
United States Senator

Cc: Michele M. Leonhart, Administrator, Drug Enforcement Administration

David Houlihan MD Iowa Ethics
Complaint and Settlement.

- 1) He was still hired by the VA and then promoted to Chief of Staff for Tomah VA and all outlying clinics in Western Wisconsin

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF IOWA

IN THE MATTER OF A CONFIDENTIAL INVESTIGATION CONCERNING

DAVID J. HOULIHAN, M.D., RESPONDENT

No. 02-01-1429

SETTLEMENT AGREEMENT and FINAL ORDER

COMES NOW the Iowa Board of Medical Examiners (the Board), and David J. Houlihan, M.D., (Respondent), on April / 3, 2003, and pursuant to Iowa Code sections 17A.10(2) and 272C.3(4), and enter into this Settlement Agreement and Final Order to resolve the contested case currently on file.

1. Respondent was issued license number 29739 to practice medicine in Iowa on February 16, 1994.
2. Respondent's Iowa medical license is valid and will next expire on February 1, 2004.
3. A Statement of Charges was filed against Respondent on June 5, 2002, and is awaiting hearing.
4. The Board has jurisdiction over the parties and subject matter.

5. On or about April 25, 2002, Respondent completed a comprehensive professional boundary evaluation under the direction of Gene G. Abel, M.D. at the Behavioral Medicine Institute of Atlanta, 1401 Peachtree Street, Suite 140, Atlanta, Georgia.

6. Within 14 days of the date of this Order, Respondent shall contact Deb Anglin, Coordinator, Monitoring Programs, Iowa Board of Medical Examiners, 400 SW 8th Street, Suite C, Des Moines, IA 50309-4686, Ph. #515-281-6491, to schedule a professional boundary education program. Within 90 days of the date of this Order, Respondent shall successfully complete an education program on physician-patient boundaries in the practice of psychiatry under the direction of John Hung, Ph.D., at Health Psychology Consultants, 7301 Ohms Lane, Suite 365, Edina, Minnesota. All costs associated with the boundary education program shall be Respondent's responsibility.

7. Respondent shall obey all federal, state and local laws, and all rules governing the practice of medicine in Iowa.

8. In the event Respondent violates or fails to comply with any of the terms or conditions of this Settlement Agreement and Final Order, the Board may initiate action to suspend or revoke Respondent's Iowa medical license or to impose other license discipline as authorized in Iowa Code Chapters 148 and 272 and 653 IAC 12.2.

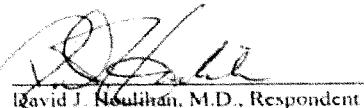
9. This Settlement Agreement and Final Order constitutes the resolution of a contested case proceeding.

10. By entering into this Settlement Agreement and Final Order, Respondent voluntarily waives any rights to a contested case hearing on the allegations contained in the Statement of Charges and waives any objections to the terms of this Settlement Agreement.

11. This Settlement Agreement and Final Order is voluntarily submitted by Respondent to the Board for consideration.

12. This Settlement Agreement and Final Order is subject to approval by the Board. If the Board fails to approve this Settlement Agreement and Final Order, it shall be of no force or effect to either party.

13. The Board's approval of this Settlement Agreement and Final Order shall constitute a **Final Order** of the Board.



David J. Neulihan, M.D., Respondent

Subscribed and sworn to before me on March 13, 2003.

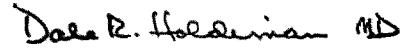
Notary Public, State of Wisconsin



Ramona L. Rattunde

This Settlement Agreement and Final Order is approved by the Board on

April 1 3, 2003.



Dale R. Holdiman, M.D.

Dale R. Holdiman, M.D., Chairperson
Iowa Board of Medical Examiners
400 SW 8th Street, Suite C
Des Moines, Iowa 50309-4686

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF IOWA

IN THE MATTER OF A CONFIDENTIAL INVESTIGATION CONCERNING

DAVID J. HOULIHAN, M.D., RESPONDENT

No. 02-01-1429

STATEMENT OF CHARGES

COMES NOW the Iowa Board of Medical Examiners (the Board), on
June 5, 2002, and files this Statement of Charges against David J. Houlihan, M.D.,
(Respondent), a physician licensed pursuant to Chapter 147 of the 2001 Code of Iowa and
alleges:

1. Respondent was issued license number 29739 to practice medicine and surgery
in Iowa on February 16, 1994.
2. Respondent's Iowa medical license is valid and will next expire on February 1,
2004.
3. The Board has jurisdiction in this matter pursuant to Iowa Code Chapters 147,
148 and 272C.

COUNT I

4. Respondent is charged under Iowa Code section 147.55(3) (2001) and 653 IAC section 12.4(3) with engaging in unethical conduct or practice harmful or detrimental to the public when he violated appropriate professional physician/patient boundaries.

CIRCUMSTANCES

5. Respondent, a psychiatrist practicing in Iowa, inappropriately hired patients and/or former patients to perform work for him.

6. Respondent inappropriately possessed patient medications at his home.

7. Respondent engaged in an inappropriate social relationship with a patient

8. The Board referred this matter to a peer review committee consisting of two Iowa licensed psychiatrists. The peer review committee concluded that Respondent failed to maintain proper boundaries with respect to his relationship with a former patient.

On this the 5th day of June, 2002, the Iowa Board of Medical Examiners finds
probable cause to file this Statement of Charges.



Dale R. Holdiman, M.D., Chairperson
Iowa Board of Medical Examiners
400 SW 8th Street, Suite C
Des Moines, IA 50309-4686

Media Fact Checking

- 1) Enlisted DD214
- 2) Officer DD214
- 3) West Point Transcripts

TO BE USED FOR IDENTIFICATION PURPOSES		THIS IS AN IMPORTANT RECORD SAFEGUARD IT			ANY ALTERATIONS IN SHADED AREAS RENDER FORM VOID		
CERTIFICATE OF RELEASE OR DISCHARGE FROM ACTIVE DUTY							
1. NAME (Last, First, Middle) HORN, RYAN ALLAN		2. DEPARTMENT, COMPONENT AND BRANCH ARMY-USMA-CADET			3. SOCIAL SECURITY NO.		
4a. GRADE, RATE OR RANK PFC	4b. PAY GRADE E-3	5. DATE OF BIRTH (YYMMDD) 720212	6. RESERVE OBLIG TERM DATE Year: 98 Month: 01 Day: 02				
7a. PLACE OF ENTRY INTO ACTIVE DUTY MINNEAPOLIS, MN		7b. HOME OR RECORD AT TIME OF ENTRY (City and state, or complete address if known) BURNSVILLE, MN					
8. LAST DUTY ASSIGNMENT AND MAJOR COMMAND USMAPS Candidate, Fort Monmouth - SF		8b. STATION WHERE SEPARATED USMA West Point, New York					
9. COMMAND TO WHICH TRANSFERRED USARPERCEN Com Sp (REINF) St. Louis, MO 63132-5200		10. SGLI COVERAGE Amount: \$ 100,000					
11. PRIMARY SPECIALTY (List number, title and years and months in specialty, list additional specialty numbers and dates involving service of one or more years) 12B1C, COMBAT ENGINEER--1 YR AND 7 MOS//NOTHING FOLLOWS		12. RECORD OF SERVICE YR/MONTH DAY a. Dates Entered AD This Period 90 08 14 b. Separation Date This Period 92 06 28 c. Total Active Service This Period 01 10 15 d. Total Prior Active Service 00 00 00 e. Total Prior Inactive Service 00 00 00 f. Foreign Service 00 03 00 g. Total Service 00 06 00 h. Effective Date of Pay Grade 91 05 01					
13. DECORATIONS, MEDALS, BADGES, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED (All periods of service) GOOD CONDUCT MEDAL//NATIONAL DEFENSE SERVICE MEDAL//ARMY SERVICE RIBBON// SOUTHWEST ASIA SERVICE MEDAL W/3 BRONZE SERVICE STARS//KUWAIT LIBERATION MEDAL//EXPERT QUALIFICATION BADGE W/HAND GRENADE BAR// (CONT'D. IN BLOCK 18)							
14. UNITED STATES MILITARY ACADEMY PREPARATORY SCHOOL, 42 WEEKS (JUN 92) // COMBAT ENGINEER COURSE, 13 WEEKS (NOV 90) //NOTHING FOLLOWS							
15a. MEMBER CONTRIBUTE TO POST-SECONDARY IN-RETRAINING EDUCATIONAL ASSISTANCE PROGRAM <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		15b. HIGH SCHOOL GRADUATION OR EQUIVALENT <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		16. DAYS ACCRUED LEAVE PAID NOTH			
17. MEMBER WAS PROVIDED COMPLETE DENTAL EXAMINATION AND ALL APPROPRIATE DENTAL SERVICES AND TREATMENT WITHIN 90 DAYS PRIOR TO SEPARATION <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
18. REMARKS The information contained herein is subject to computer matching within the Department of Defense or with any other affected Federal or Non-Federal Agency for verification purposes and to determine eligibility for, and/or continued compliance with, the requirements of a Federal Benefit Program. Block 6 includes period of DEPs: 900103-900813//Excess leave (creditable for all purposes except pay and allowances) - 15 days: 920612-920626// Block 13 Cont'd: Sharpshooter Qualification Badge w/Rifle (M-16) Bar// NOTHING FOLLOWS							
19a. MAILING ADDRESS AFTER SEPARATION (Include Zip Code) United States Corps of Cadets USMA West Point, New York 10597-1962				19b. NEAREST RELATIVE (name and address, include Zip Code) PAMELA H. LOZELLO, Chief, PARS			
20. MEMBER REQUESTS COPY OF SEPARATION <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		22. OFFICIAL AUTHORIZED TO SIGN (typed name, grade, title and signature) PAMELA H. LOZELLO, Chief, PARS					
► SPECIAL ADDITIONAL INFORMATION (For use by authorized agencies only)							
23. TYPE OF SEPARATION Relief from Active Duty		24. CHARACTER OF SERVICE (Select one) Honorable					
25. SEPARATION AUTHORITY Section 11, Para 5d(2), AR 612-205		26. SEPARATION CODE NG			27. REENTRY CODE RE-2		
28. NARRATIVE REASON FOR SEPARATION To enter Service Academy							
29. DATES OR TIME LOST DURING THIS PERIOD NOTHING				30. MEMBER REQUESTS COPY A			

CAUTION: NOT TO BE USED FOR
CERTIFICATION PURPOSES

THIS IS AN IMPORTANT RECORD
EASILY GUARDED

ANY ALTERATIONS IN SHADDED
AREAS RENDER FORM VOID

CERTIFICATE OF RELEASE OR DISCHARGE FROM ACTIVE DUTY

1. NAME (Last, First, Middle)		2. DEPARTMENT, COMPONENT AND BRANCH		3. SOCIAL SECURITY NO.				
HORN, ERVAN ALLAN		ARMY/RA, IN		000-000-0000				
4. GRADE, RATE, OR RANK		4.6 PAY GRADE		6. DATE OF BIRTH /YYYYMMDD/		8. RESERVE OBLIG. TERM. DATE		
1LT		O2		19720212		Year 0000 Month 00 Day 00		
7. PLACE OF ENTRY INTO ACTIVE DUTY				7 b - CME OF RECORD AT TIME OF ENTRY (City and state, or complete address if known)				
MINNEAPOLIS, MN				BURNSVILLE, MN 55337				
8. LAST CITY ASSIGNMENT AND MAJOR COMMAND				8 b STATION WHERE SEPARATED				
USAG DRAGON BDE FC				PORT BRAGG, NC 28307-5000				
9. COMMAND TO WHICH TRANSFERRED				10. SOLI COVERAGE		None		
NA				Amount \$ 200,000.00				
11. PRIMARY SPECIALTY (list number, title and years and months in parentheses, list additional specialty numbers and titles involving overseas service of more than 1 year) 11a. SP INSPECTOR--2 1985-8 MOS//NOTHING FOLLOWS								
12. RECORD OF SERVICE								
a. Date entered AD This Period 1996 06 05								
b. Separation Date This Period 1999 03 30								
c. Net Active Service This Period 0002 08 00								
d. Total Prior Active Service 0001 00 00								
e. Total Prior Inactive Service 0000 00 00								
f. Foreign Service 0000 00 00								
g. Sea Service 0000 00 00								
h. Effective Date of Pay Grade 1998 04 16								
13. DECORATIONS, MEDALS, BADGES, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED (All periods of service) ARMY GOOD CONDUCT MEDAL//NATIONAL DEFENSE SERVICE MEDAL//SOUTHWEST ASIA SERVICE MEDAL (3RD ANNUAL)//ARMY SERVICE RIBBON//KUWAIT LIBERATION MEDAL//KUWAIT LIBERATION MEDAL (K)//PARACHUTIST BADGE//AIR ASSAULT BADGE//NOTHING FOLLOWS								
14. MILITARY EDUCATION (Course title, number of weeks and month and year completed) NONE//NOTHING FOLLOWS								
15. MEMBER CONTRIBUTED TO POST VIETNAM ERA VETERAN'S EDUCATIONAL ASSISTANCE PROGRAM		Yea <input checked="" type="checkbox"/> N <input type="checkbox"/>	16. HIGH SCHOOL GRADUATE OR EQUIVALENT		Yea <input type="checkbox"/> N <input checked="" type="checkbox"/>	18. DAYS ACCRUED LEAVE PAID		
X NONE								
17. MEMBER HAS PROVIDED A COMPLETE DENTAL EXAM AND ALL APPROPRIATE DENTAL SERVICES AND TREATMENT WITHIN 90 DAYS PRIOR TO SEPARATION <input type="checkbox"/> X <input checked="" type="checkbox"/>								
18. REMARKS DATA HEREIN SUBJECT TO COMPUTER MATCHING WITHIN DOD OR WITH OTHER AGENCIES FOR VERIFICATION PURPOSES AND DETERMINING ELIGIBILITY OR COMPLIANCE FOR FEDERAL BENEFITS//MEMBER HAS COMPLETED FIRST FULL TERM OF SERVICE//NOTHING FOLLOWS								
19. MAILING ADDRESS AFTER SEPARATION (include Zip Code) 500 STILLPOND LN, CAMERON, NC 28326 20. NEAREST RELATIVE (Name and address - include Zip Code)								
20. MEMBER REQUESTS COIN & BEAN TO: NO DEPT OF VET. AFFAIRS <input checked="" type="checkbox"/> Yea <input type="checkbox"/> N <input type="checkbox"/> 22. OFFICIAL AUTHORIZED TO SIGN (Type or name, title, date and signature)								
21. SIGNATURE OF MEMBER BEING SEPARATED Ervin A. Horn Jeffrey V. Triniber, Spec. USA, Medic, Trans Sv								
23. SPECIAL ADDITIONAL INFORMATION (For legacy selected agencies only)								
24. TYPE OF SEPARATION		24. CHARACTER OF SERVICE (check one or more)						
RETIREMENT		HONORABLE						
25. SEPARATION AUTHORITY		26. SEPARATION CODE		27. REENTRY CODE				
AB 619-40, PARA 4-2B(2)		SPR		NA				
28. NARRATIVE REASON FOR SEPARATION DISABILITY, TEMPORARY								
29. DATES OF TIME LOST DURING THIS PERIOD								
30. MEMBER REQUESTS COPY A Ervin A. Horn								

ACADEMIC RECORD SHEET - POLYGRAPHIC				WEST POINT, NEW YORK 10598		
ACADEMIC RECORD OF RYAN ALLAN HORN				DATE 7 MAY 97		
DATE OF 1996				TIME		
ENROLLED 29 JUN 92				TERM		
DATE OF BIRTH 12 FEB 72				GRADE		
ATTENDED BURNSVILLE SENIOR HIGH SCHOOL BURNSVILLE MN 55337				CREDIT HOURS		
FROM SCHOOL/COLLEGE USMA, PREP SCHOOL		FORT MONMOUTH NJ 07703				
GRADE NUMBER	COURSE TITLE	GRADE NUMBER	COURSE TITLE	CREDIT HOURS	CREDIT HOURS	
1ST TERM 92-93						
CS1005	INTRO TO COMPUTERS & PASCAL	3.0	A	HI201	HISTORY OF THE MILITARY ART	
BN1004	COMPOSITION	3.0	A	HI1001	HISTORY OF CIVILIZATION I	
HI1004	HISTORY OF THE WORLD	3.0	A	HI2002	SURVEY OF HISTORY I	
LC1003	CHINESE I (STANDARD)	3.0	A	LP1004	SURVEY OF FRENCH LIT I	
MA1003	DISCRETE DYNAMICAL SYS	3.0	A	MD301	2ND CLASS MILITARY DEV I	
MD101	4TH CLASS MILITARY DEV I	4.0	A	SS107	INTERNATIONAL RELATIONS	
OPA	CUR 3.51 CUM 3.51	0.0	P	OPA	CUR 3.52 CUM 3.32	
DEAN'S LIST						
2ND TERM 92-93						
EN1008	LITERATURE	3.0	B	EN302	ADVANCED COMPOSITION	
HI1008	ADV HISTORY OF THE WORLD	3.0	B	HI1002	HISTORY OF THE MILITARY ART	
LC1004	CHINESE I (STANDARD)	3.0	B	MD302	2ND CLASS MILITARY DEV II	
MA1004	CALCULUS	3.0	B	MD303	COMBINED ARMS OPERATIONS II	
MD1004	4TH CLASS MILITARY DEV II	3.0	B	MS1001	PHYSICS I	
SS1004	MAP READING-SMALL UNIT TACT	3.0	B	PL1001	SPIRIT & SPOT DEV'LNT-MEN	
SS1005	PHYS ED FOUNDATIONS-MEN	3.0	B	SS1001	MILITARY LEADERSHIP	
SS1006	GENERAL PSYCHOLOGY	3.0	B	SS1002	ENGINEERING ECONOMY	
OPA	CUR 3.29 CUM 3.39	0.0	P	SS1007	DETERMINISTIC MODELS	
DEAN'S LIST						
4TH TERM 92-93						
MD200	CADET FIELD TRAINING	6.0	P	MD400	CBT/CPT/SGR CADRE & CULT IC 0.0	
OPA	CUR 0.00 CUM 3.39	0.0	P	OPA	CUR 0.00 CUM 3.27	
1ST TERM 93-94						
BN1004	ADV GENERAL CHEMISTRY I	3.0	B+	LN1001	NATURE OF MODERN LANGUAGES	
BN1004	INTERMEDIATE CHINESE	3.0	B+	LN1002	ADV STUDY-FOREIGN LANGS	
BN1004	ADV FRENCH	3.0	B+	MD301	2ND CLASS MILITARY DEV I	
MA1004	CALCULUS	3.0	B+	MS1001	PHYSICS I	
MD201	3RD CLASS MILITARY DEV I	3.0	B+	SS1001	PROBABILISTIC MODELS	
SS1001	PHILOSOPHY	3.0	B+	SS1001	INTRO TO SYSTEMS DESIGN	
SS1002	ADV ECON: PRINCIPLES & PROB	3.0	B+	OPA	CUR 2.91 CUM 3.22	
OPA	CUR 3.21 CUM 3.33	0.0	P	2ND TERM 93-94		
DEAN'S LIST						
2ND TERM 93-94						
BN1002	ADV GENERAL CHEMISTRY II	3.0	B+	EV1005	CULTURAL & POLITICAL GEOG	
BN1002	TERRAIN ANALYSIS	3.0	B+	LP3002	MILITARY READINGS IN FRENCH	
BN1002	CONVERSATIONAL CHINESE	3.0	B+	LN402	SPOKEN GERMAN	
BN1002	ADV CHINESE LITERATURE	3.0	B+	LW4002	CONSTITUTIONAL/MILITARY LAW	
BN1002	PROBABILITY & STATISTICS I	3.0	B+	MD402	1ST CLASS MILITARY DEV II	
BN1002	4TH CLASS MILITARY DEV I	3.0	B+	MS1002	LORENTZ/TRADE & PORT DEV(MEN)	
BN1002	COMBINED ARMS OPERATIONS I	3.0	B+	SS1002	SYSTEMS DESIGN	
BN1002	ADV SKILLS DEV/UNIT FITNESS	3.0	B+	OPA	CUR 2.74 CUM 3.17	
SS1004	PHILOSOPHY OF SCIENCE	3.0	B+	GRADUATED 01 JUN 1996 WITH		
SS1002	ADV AMERICAN POLITICS	3.0	B+	BACHELOR OF SCIENCE DEGREE		
OPA	CUR 2.06 CUM 3.19	0.0	P	FOREIGN LANG MAJOR: CHINESE & FRENCH		
DEAN'S LIST						
4TH TERM 93-94						
LN1001	FRENCH W1	3.0	A			
MD300	CBT/CPT CADRE & CULT-2ND CL 0.0	0.0	P			
OPA	CUR 4.00 CUM 3.21	0.0	P			

Additional Information for the Record
Provided by Ryan Honl

I wanted to submit the following answer for the record to a great question Congressman Kind asked me concerning any suggestions I have related to staff better triaging concerns with VA complaints.

As I pointed out in the hearing, the most important thing is for the President to nominate a new Inspector General that doesn't hide reports from Congress and conducts investigations with transparency so congressional offices don't need to get involved in the first place since employees would trust the VA IG and leadership to investigate. Getting more specific to what Congressman Kind asked, I believe there are two tracks of VA complaints that a vet staffer could easily rank order in an excel spreadsheet for follow up. In columns, there would be basic information (facility name, complaint, contact info, etc). Most importantly a ranking system by complaint that a staffer could use the excel sort function by rank through a 1-10 number system or highlight with colors using red, yellow, green, etc, which can also be color sorted.

1) Veteran complaints: examples of lowest priority sent to facility level for director response; veteran can't get a hearing aid, problems with compensation, etc. Most serious, Constituent had to wait 3 hours in the emergency room at the Tomah VA while having a heart attack - send that to VA Central Office/OIG

2) Employee complaints: lowest priority for facility level example - employee got a bad review from their boss - send to facility. Most serious would be patient harm or death, gross waste/fraud/abuse, etc - send to VA Central Office/OIG.

I use these as examples. I am sure there are more venues to send complaints and categories of complaints, but hopefully you see where I'm going. Of most importance is continual staff follow up, especially with the most serious complaints. If the VA hasn't responded, there should be a short time frame for response and continual regular contact until resolution with the VA and the constituent. The key is to translate complaints from initial contact into a data driven rank ordered system which is why I recommend excel. Staff supervisors could monitor the spreadsheet for follow up with the staffer to ensure accountability.

I hope the overall concept is useful. It may be me reinventing the wheel, but with that kind of system I believe a lot of the problems with the staff work surrounding the Tomah complaints over the years could have been prevented and quite possibly saved lives.

Again, there is great mistrust currently among veterans and employees with VA leadership. Therefore of most immediate concern is swiftly holding VA leadership accountable. However, if the IG is incompetent, even the good leaders in the VA will either stay in the dark and/or have reports that don't substantiate clear wrongdoing, so replacing the IG is warranted at this time. It is clear whether it's not substantiating the direct cause of deaths in Phoenix due to wait times or entire pharmacies calling for help in Tomah, the current IG has failed to perform his duty. Only the President can fix that one and only Congress through elected representation can call for bipartisan action. It's common sense to veterans and should be to elected leaders as well. I know

we're dealing with federal employees, but veterans have experienced quicker justice in the military where leaders are relieved of duty for actions as simple as creating harmful command climates. Then they enter the VA system whether as a veteran or employee and the perception is that acts of Congress can't even remove leaders who have mismanaged at different levels of the VA.

I'm always available for additional questions.

My name is Marv Simcakoski,

I am Jason Simcakoski's Dad. I want to start off by saying August 30th, 2014 was the hardest and most painful day of my life. There isn't a day that goes by when I don't re-live that morning. I regret leaving my son in his room alone that morning only to get a call hours later that he had stopped breathing. I can't get that thought out of my head; I wish I would have been there for him. I loved my son and still do with all my heart and I miss him badly. He was proud to be a Marine and to serve his country and he loved his fellow marines. This is a summary of some of the important issues to the committee as I understand them. Over the last couple of years, Jason would tell me how frustrated he was with his weight problem and his lack of motivation to do anything. I really got to know and understand how he struggled with his addiction problem only to have it over fueled time and time again by the Tomah VA doctors. I have argued with my sons Doctors for the last 4 years about how I could see they were over-medding him. I was always told that I wasn't their patient, even though I was his Dad who truly cared about him a lot more than they did! What I would like to know is if Jason was their son, would they of had him on all of these Meds? And would they have been there, fighting for their son with the doctors, as I was with Jason? I would like one of the doctors to tell me how is it helping a patient when you give them meds to get going such as Adderall, and meds to make you tired such as Clonazepam, Lorazepam, Temazepam? I watched Jason go up and down because he worked with us in the family construction business. He would be all hyper in the morning and then out of it in the late afternoon from all these meds that were killing him. When my son came home from one of his inpatient stays, the doctor had him on so many meds both I and Jason were confused by all the different meds he had to take. One morning, about 3 years ago his daughter informed us to check on him because he didn't seem right. She was only 8 years old and knew he wasn't right. So my other son Chad and I went to his house only to find him barely able to get up out of bed. Once he did he his skin started popping all over his entire body and his words echoed like this iiiicccccaaaaannnnnssssssoooo, he started falling down. We called the ambulance and held him up and I kept telling him, "Jason please don't die", as we were sobbing waiting for the ambulance to arrive. He survived that time, and later I found out why that happened. Because his doctor sent him a 3 month supply of Lorazepam and he took all of them in 4 days. What made me mad, why would a doctor that works with patients, with addiction problems send a patient 3 months' worth of Benzodiazepines????? I asked my son if he took all those meds because he wanted to die? He said he never thought about dying. He said as he took a few of them and laid back down and pretty soon his mind kept fighting him and telling him he needed more and more and pretty soon he was taking them by the handfuls not thinking of any consequences. After

this happened, his doctor started doing a real good job with my son and not giving him the Benzodiazepines and eliminating some of the other meds. My son started doing a lot better and I started giving him his meds daily seven days a week. He seemed a lot better. He was working every day starting to lose weight and was feeling better. Then one day about 1 year ago his little dog that he loved got run over by a car right in front of him and shortly after that an old friend he knew died and he started to unravel. I took him back to the VA and he had a new inpatient doctor. My wife, Jason and I, met with her and discussed my sons treatment plan. She told us that he didn't need all the meds and she was going to take him off most of them. After we left that day, we were happy. My wife and I thought she was going to be great doctor, she understood. My son stayed there for 3 months. Towards the end of his 3 month stay in 2014, he was doing real good until his doctor put him on a new drug, Geodine, then everything started to spiral downhill. His anxiety level went way up, he couldn't sleep, he started having bad thoughts, he told his doctor of all these issues, and that he didn't want to take the medicine anymore. She told him if you don't take it, you will be discharged the next morning. So he kept taking it until he couldn't take it anymore. He pulled the fire alarms and went crazy then his doctor was going to put him in a lockdown for 2 months for it. My son made a good point to me, he said, "Why am I getting punished for something she made me take?" Dr. Davis then gave my son the option of going to the Madison facility or into the lockdown at the Tomah VA. He did not want to go into lock down, so he was transferred to Madison that same day. He was told there that he was over-medded on Valium and on the Geodine, and that the Geodine can make people crazy like what happened to my son. They released him the next day only to have him come home and try to wean down on these meds on his own, which I know is next to impossible. After being home for about two weeks, my son still couldn't do much more than get out of bed and eat so I took him back to Tomah VA the day after my father's funeral. And by the way, my son wasn't even able to attend his grandfather's funeral because of the withdrawals; he was supposed to be a pallbearer. He told me on the way down to Tomah that if he could be like anybody he would like to be like his brother Chad, because he was normal and didn't have all of these daily struggles like him. The last two weeks that Jason was in Tomah, he was doing ok until his doctor put him back on Geodine. He sent me a text 4 days before he died and told me he couldn't take it anymore he was going crazy and he reached out to me to help him. I called to various offices above his doctor and my son called me back and said within two hours someone was helping him. I met with his doctor the next day on Thursday with my son and a patient advocate. When we all sat down in the room his doctor turned and pointed to me and said that I caused her a lot of trouble. She said she spent 2 ½ hours in meetings because I went over her head and said she could have been taking care of my son. She also said I may know how to

build houses and pound nails but I don't know anything about taking care of my son. This really hit me hard to have his doctor tell me I don't know my son and I caused her a lot of trouble for trying to help my son who needed my help. The reason I called over her head is that my son wasn't receiving the care from here he needed. He had to write notes to the nurses to give to his doctor because she wouldn't come see him! Jason called me the night before he died and wanted me to bring his truck that next morning, he was doing a lot better. He was all excited about coming home that following Monday, for his daughter's birthday that week. I told him I would be there before 9:00 am. His wife, daughter and I arrived there before 9:00am. Usually when I come to see him he is waiting outside or upstairs on his floor for us, but this time there was no Jason. I went to the nurse's station and asked where he was and they said he was in his room with a migraine, which was strange because he never had a migraine before. So we went in his room and he was lying on his side with his hand on his head. I asked him what was the matter and when he started to talk I couldn't understand him because they had him so medded up. I went to the nurse's station and asked them why he was so medded up and the nurse told me he will be fine in a couple hours. That they gave him another med for a migraine. This med did not show up in his autopsy report this was Fioricet. I went back to his room and we stayed a little longer, he waived us off to go and he went back to sleep. We left not knowing that we would never see him alive again! Then about 5 hours later I get a call from the VA that my sons breathing stopped. They were working on him to try to resuscitate him but it was too late. He never got to drive his truck or come home for his daughter's birthday. Then I find out he was on all of these meds, when the doctor told us she was going to be taking him off most of them, I think that was insane. And later I find out they had my son on pain meds (Tramadol) and sent him a bottle of 50 to his house. So why do you put someone with an addiction to pain meds on pain meds? I can't begin to tell you how angry that makes me! I would like one of these doctors to tell me how mixing all of these drugs they had my son on was going to do him any good! Why doesn't the director of the VA facility take the blame for all of this, isn't he in charge? I'm an independent contractor in the Stevens Point area and when anyone that works under me on my jobsite does something wrong, I am responsible because I am in charge. If this facility will not take responsibility for its wrong doing, then I think this system is totally screwed up. I think all who had a part in my son's death should be held accountable, if they aren't then what kind message are we sending? It's not ok to have a patient die in the mental health ward, because of being over medded by the doctors and no one is at fault. If after today's hearing, nothing major gets changed, then I think people will lose faith in our Government. Let's not let all of this fade away, let's make some historic changes that we can all be proud to be a part of. Give these veteran men and women a fighting chance for a bright future instead of a cloudy one from being

over medded so they know what it feels like to be normal. I think this is going to be a great chance to have all government parties' work together to show the veterans they all really do care. After all, these people should be the most important priority to all of us because they are the real life heroes of this country! I am proud my son was veteran and he will always be my HERO!!!!

Statement of Heather Simcakoski**"Tomah VAMC: Examining Quality, Access, and a Culture
of Overreliance on High-Risk Medications"**
March 30, 2015

My name is Heather Simcakoski. I am the wife of Jason Simcakoski and mother of our 12 year old daughter Anaya Simcakoski.

Jason and I met 13 years ago, while both serving in the Marine Corps together in Hawaii. After the Marine Corps I moved from my hometown in Ohio to Wisconsin; Stevens Point is Jason's hometown and where he had dreams of one day taking over his family business - along with so many other dreams for our future!

Even when life seemed impossible and we questioned ourselves - we always found the strength and love to work through it. Neither of us could ever give up on each other or our marriage. Our daughter Anaya has been cheated out of every Father's Day, having a father at her soccer games, having her dad to walk her down the aisle one day, and most importantly she was cheated out of his unconditional love, support, and guidance in life.

Jason was not only my best friend and husband - he was my family. When my mother passed away three years ago; the same day I was diagnosed with cancer (leaving me with no parents) he was the one that was there for me during the most difficult times in my life - he was my rock, I could always count on his love. He drove 9 hours in the middle of the night to be by my side during emergency surgery. He is the person I called when I had something to talk about; whether it was good or bad - he was always the person I talked to - that has been taken from me. During treatment, I never had to question if he would leave, he loved Anaya and me unconditionally. Jason was a good person with such a good heart and was taken far too early from us - this is not how he deserved to lose his life.

Because of the treatment Jason received at the VA, the only family I had here - aside from our daughter was him and I still do not know that we will ever find peace; because, in my heart I know he should still be here with us today. Anaya and I lost more than a husband and a father; we lost part of ourselves - a part that I don't know if you ever get back.

With this, it is so heartbreaking to know that someone with such love and passion for helping others has been taken from Anaya and I - and I truly believe in my heart that he would be here today if he had the proper treatment.

I have so many questions, which I hope to find answers for.

I would like to understand why/how Jason's police reports "disappeared?" There are reports that were made to DR Houlihan, the Tomah VA, the Tomah City Police Department as well as the FBI - regarding patients selling their prescriptions back in 2013- making so much money that they had saved enough to put a down

payment on a house. Thankfully I have voicemails and text messages between Jason and the officers – otherwise I am not convinced anyone would be listening to this point today. I would like to understand who is responsible for these reports, where they are, and why no one did anything with the reports?

Additionally when you are managing someone with addiction to prescriptions – or anyone for that matter, once they are admitted into inpatient care – why do they still continue to receive medication by mail – the same medications they are receiving while at the facility?

I also have concerns about the way Jason was treated by the DR as a patient when he complained that his medication was making him uncomfortable one evening. He knocked on the physician's door and she opened it and slammed it shut in his face. He was not a prisoner nor was he in boot camp any longer – he is a veteran of who was willing to sacrifice his life every single day for each and every single one of us – including those treating him, and to know that this is how they treat their patients is devastating and completely unacceptable.

Also, living with Jason I was able to see the long term impact of all of the medication. I would see him falling asleep while he was eating, driving on the median, slurring his words, unable to work, sleeping 18+ hours a day. Jason did not even realize his behavior was so erratic at times that there were instances where I would have to video record it and show him later so he would see what I saw. I would like to understand how a DR can prescribe 14 different medications and know which ones are and are not working.

When you have that many medications in your system – your mind is altered. At that point, I question how a patient could even articulate to a DR what "normal" feels like anymore....Especially after mixing and matching (in my opinion) – experimenting with medication on our veterans – my husband.

I would like to also understand why alternative treatments were not tried for Jason? After years of prescription treatment he was not rehabilitated. Does the VA only believe in treating addiction by replacing one addictive medication with several others? I personally do not consider this success.

They did not just take away a person – they took away a hero, a friend, a husband, a father, a brother, and a son. Everywhere we go and everything we do – there are constant reminders of Jason's life and it is so unfair to him and every single veteran out there to think that this is the type of treatment that is acceptable.

Veterans whom are willing to sacrifice their life for you (everyone in this room and country) – they deserve so much more than second class healthcare. They should be proud to walk into a VA medical center to receive care; it should be world class treatment – not a last resort for those with no alternate health insurance. This should be the last place cuts are ever made on spending.

I believe our family and every single veteran deserves answers and there should be significant strides made to rebuild the trust of all veterans – that they can trust that they will receive the highest quality healthcare from the VA – regardless of the cost. I also feel we all deserve to know how to push for change effectively. I say this with no sarcasm intended, but currently it seems the only way to get anyone to do the right thing is to involve the media. I ask myself today – if they had not reported on this story, would anything ever change at the Tomah VA? I would like to understand how processes can be put into place to ensure there is accountability without such extreme measures.

Candace Delis

Prepared statement for:

Senate Committee on Homeland Security and Governmental Affairs and the House Committee on Veterans' Affairs
on March 30, 2015.

50 years is a long time to keep a secret.

My father, Thomas Baer, was drafted and served proudly in the US Army until he was medically discharged with a service connected mental health issue. Between the time he left the Army in 1965, until his death in January, 2015, he was treated off and on and hospitalized at several VA hospitals. One was Fitzsimons Army Hospital in Aurora, Colorado, which is now closed. Another was the St. Cloud, Minnesota VA Hospital. The most recent – and the last – was the Tomah VA. He was hospitalized and treated twice in the inpatient mental health unit at the Tomah VA, once in 1970, shortly after he met my mother, and again in 1982.

He and my mother remained silent about his illness. Even keeping it from me until I was in my late teens, in an attempt to protect me from the realities they both dealt with daily. Until today, aside from me, my mother, and a handful of close friends, no one other than his doctors knew of his struggle. Because there was, and still is (maybe to a lesser degree), a stigma that goes along with mental health issues. A stigma that causes feelings of shame, fear, and hopelessness. A stigma that leads to blame, discrimination, and misrepresentation in the media. That is why I have not spoken in detail about this until now.

My father was treated at Marshfield Clinic Marshfield Center on Friday, January 9th, 2015, for a bronchial infection. He was prescribed steroids as well as an antibiotic. Over the course of the weekend, his behavior had changed and he was restless, confused, and dizzy – symptoms related to his mental health issues, and symptoms that can be triggered by steroids. So on January 12th, we tried to make an appointment for him to see his regular provider at the Marshfield Clinic, but were unable to do so due to scheduling. My mother and I discussed it with my father, and he felt as though he may need to be hospitalized, so we called the Tomah VA. We explained the symptoms that we thought were mental health related, as well as the symptoms of the bronchial infection, which included trouble breathing, and the fact that he also had COPD. We were told we could bring him down and he would be evaluated.

There is an important point I would like to make. We have been questioned by cowardly, anonymous Tomah VA employees on news websites and on forums. One of which hid behind the screen name "TomahRN". These employees disingenuously ask, "Why didn't you take him to the local hospital?" Here are our reasons why: first, trust; second, fear; and third, duty.

First, we trusted the VA nurse who told us to bring him after we told her his symptoms. We trusted her medical knowledge and training, and believed she would tell us to go elsewhere if it sounded like his symptoms were life-threatening or that VA could not treat him there. We trusted that she was confident the Tomah VA could treat my dad in a compassionate and competent manner after driving 60 miles.

Second, we feared VA would stick my parents with the medical bill. When the nurse told us to come in, we were required to come in under implicit threat that my parents would bear the burden of enormous medical fees. You see, in the 90's, my dad had a similar emergency. My parents made the mistake of seeing a community doctor with no prior approval during the emergency and VA stuck my parents with a bill for thousands of dollars.

Third, and most important, Veterans Affairs has a duty to competently treat our nation's veterans in exchange for our veterans fulfilling their duty to protect our country. My dad was entitled to competent care and VA had a duty to provide it. I would not be here today if VA fulfilled its duty to my dad.

I have thought long and hard about those anonymous, public jabs at our grieving family from Tomah VA employees. Shame on you, whoever you are, because our trust in Veterans Affairs, and in you to fulfill your duty, is what killed my dad.

Here is how it happened.

We arrived at the Tomah VA Urgent Care at approximately 11am. When we checked in, I explained my father's symptoms and the urgency of his need to be seen. It wasn't until nearly 2 hours later, when he slumped over in the wheelchair he had been sitting in, that we were seen. He was unresponsive for several minutes. While they were trying to speak to him, I kept telling them I thought he had a stroke, since his left side was limp he was leaning in that direction, and he was unable to speak. They told me he was fine because his vitals were normal. I asked them again to please do whatever tests they could to see if he had suffered a stroke. I was told that they were too busy, and since at the time was again able to speak and respond (although barely, and not understandably), they were going to put him in a room until someone was able to evaluate him.

They did an EKG (I had to help the technician fix the machine because the paper had jammed and she didn't know how to fix it) and chest x-ray – but no tests relating to stroke, even though I had asked repeatedly. Approximately 45 minutes had passed and my father stated he needed to use the bathroom. The nurse got him up on the side of the bed, and my mom and I went outside for a few minutes to give them privacy. When we came back, no more than 5 minutes later, we came into the urgent care to hear the nurse screaming for someone to help her. We could hear her at the end of the hall, just past the nurses station where there were other staff, but no one moved to help. As my mother and I ran down the hall, we came into the room to see my father half in a chair, half on the floor, completely unresponsive, his left side again hanging limp but worse than the first time. The nurse was trying to get under him to get him back into the chair. My mother was screaming and I went to get someone to help. Finally, two other nurses came in and helped him back in the bed.

According to their website, out of the 94 doctors and nurses, the Tomah VA has one doctor that is board certified in emergency medicine.¹ This doctor is Dr. James Patterson, the doctor who was working in the Urgent Care that day, and the doctor who treated my father. Dr. Patterson said my father had suffered a massive stroke and told the nurse that a CT was needed. The nurse replied with "we can't, CT is down". Dr. Patterson said he would need to be transferred to another hospital, because they were not able to properly treat him there. I asked about the clot busting drug for strokes, but he said they could not administer the drug without first doing a CT scan.

They told us they were going to med flight him to Gundersen Lutheran Hospital in LaCrosse, Wisconsin. A few minutes later, they came back saying there were no helicopters flying, but they would not tell us why. It seemed completely strange to us since it was a clear day with no wind. We were then told he would be taken to LaCrosse via ambulance. An ambulance that they were intercepting – it was originally on its way for another patient who was having a possible heart attack.

When we arrived at the emergency room in LaCrosse, the doctors indicated that he should have been given the clot busting drug at Tomah and they could not understand why he was not, nor why he was not flown to the hospital. A CT scan was done immediately and surgery performed to remove the clot from his artery, but my father never regained consciousness.

Tuesday morning, January 13th, my mother was told by a social worker at the hospital that the VA would be paying for all of my father's medical care at Gundersen Lutheran as well as any rehab that would be needed. But my father never left the hospital alive. When they did another CT scan on Tuesday evening, they indicated he had likely suffered another stroke and had a brain bleed. After long discussions with doctors at Gundersen Lutheran about his prognosis, my mother and I decided to remove any life sustaining equipment, and at 4:20pm on Wednesday, January 14th, my father died, at the age of 74.²

¹ Tomah VA Medical Center Website – Our Doctors <http://www.tomah.va.gov/providerinfo/index.asp>

² Thomas Patrick Baer Obituary
<http://www.legacy.com/obituaries/marshfieldnewsherald/obituary.aspx?pid=173936994>

In 1982, when I was 7, I travelled to Tomah to the VA hospital with my mom to visit my dad at the inpatient mental health unit. We did this on several occasions, I am told, but I only have one memory. I remember being on an elevator inside the hospital with my mom and the doors opening between floors to a brick wall. Who knew that 32 years later I would be facing another brick wall of sorts – again at the Tomah VA.

We are left with so many unanswered questions, and the VA has been anything but "transparent".

Most people in Healthcare Facilities (including receptionists) are trained in Stoke Recognition and Response. They have badges that identify symptoms and have stroke protocols. Why did the staff seem completely unfamiliar with the symptoms of a stroke, many of which my father exhibited during the first episode in the waiting room?³

- Sudden numbness or weakness of the leg, arm or face
- Sudden confusion or trouble understanding
- Sudden trouble seeing in one or both eyes
- Sudden trouble walking, dizziness, loss of balance or coordination
- Sudden severe headache with no known cause

Why did Dr. Patterson wait until after the 2nd stroke to even suggest a CT scan? Had he suggested it after the initial stroke, maybe my father could have been moved to a better equipped facility more quickly.

Why was the CT machine "down" and for how long had it been that way?

Why did they choose to send my father 47 miles to Gundersen Lutheran Hospital in LaCrosse, instead of Tomah Memorial, which is 2 miles away from the Tomah VA? Tomah Memorial is equipped to handle stroke patients.⁴

Why were they unable to fly him to LaCrosse?

When we arrived at Gundersen Lutheran, we were told that the clot busting drug should have been administered within 1 hour of the first stroke symptoms by their neurosurgeon. Why didn't Dr. Patterson or the nursing staff treat my father's case with more urgency?

We asked many of these questions after our interview with Dr. Wesley and his team from the Inspector General's office on February 19th. We have yet to receive any responses other than their assurance they are "working on it". We have also asked for information from Leah Finch, the Acting Privacy Officer, on March 6th, and again on March 17th because she claimed to have not received our request, and as of today, we have yet to receive it.

The fact that my father, a man who proudly served his country, sat for almost 3 hours in the waiting room of the Tomah VA's "Urgent Care" department is completely unacceptable. Had they done something as simple as a CT scan at Tomah, the outcome may have been different. My mother has lost her husband of 43 years, her partner, and her best friend. My 10 yr. old step-son has lost his grandpa. And I have lost my father. The man who taught me love, compassion, and honesty. The man, who no matter what, always had time for me, and the man whose words made me feel as though I could accomplish anything.

³ American Stroke Association – Stroke Warning Signs and Symptoms
http://www.strokeassociation.org/STROKEORG/WarningSigns/Learn-More-Stroke-Warning-Signs-and-Symptoms_UCM_451207_Article.jsp

⁴ Tomah Memorial Hospital – Medical Services <http://www.tomahhospital.org/content/detail.cfm?pageid=19>

I am ashamed to live in a country where men and women are sent to fight wars where they suffer horrible injuries and mental trauma and when they return, instead of being rewarded for their service and treated with respect, they are ignored, neglected, and left to die. Like the other families here today, I am tired, and I am grieving, but I will continue to fight for justice for my father and other veterans. I want to do whatever I can to ensure that no other family has to go through what we have gone through. I want to be proud to be an American again, but without drastic and immediate change at the Tomah VA, I don't know if that is possible.

Many friends and family have asked what we will do now. We will fight back - both in the courtroom and in the court of public opinion. This morning, we filed an SF-95 claim with VA and intend to sue while getting the word out across the nation. We are represented by the leading independent journalist and attorney fighting for veterans across the country. His name is Benjamin Krause. My dad's death will not go unnoticed and VA's treatment of him will not be forgotten.

Attachments:

1. Request for SPAR (Sensitive Patient Access Report) dated 2/27/15
2. Letter from Cheryl Starkey and SPAR dated 3/2/15
3. Emails dated 2/20/15 and 3/12/15 to Stephanie Hensel (OIG) and response from Stephanie Hensel (OIG) dated 3/12/15
4. Email dated 3/13/15 from George Wesley MD (OIG) dated 3/13/15
5. Fax & Request for Federal Records to Tomah VA Privacy Officer (Leah Finch) dated 3/6/15
6. Fax cover sheets to Cheryl Starkey & Leah Finch dated 3/17/15
7. Fax delivery confirmations for faxes sent 3/6/15 and 3/17/15

Attachment #1

February 27, 2015

RE: SPAR report for Thomas Patrick Baer

To Whom It May Concern:

I am requesting the SPAR (Sensitive Patient Access Report) report for my deceased husband, Thomas Patrick Baer, from the dates of 1/12/15 through the present. His DOB is 7/18/1940 and the last 4 digits of his SSN are 6701. This report can be mailed to me at my home address. If I do not receive the report before March 12, 2015, I will be coming to the Tomah VA with my attorney to pick it up. I am enclosing a signed authorization to release medical records or health information. Please feel free to call me with any questions.

Thank you

Suzette Baer
114 West 4th Street
Marshfield, WI 54449
715-486-9580



Attachment #2

DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER
Tomah VAMC
600 E. Veterans Street
Tomah, WI 54680

March 2, 2015

Mrs. Suzette Baer

[REDACTED]

Dear Mrs. Baer:

This letter is in response to your request for a Sensitive Patient Access Report (SPAR) on your deceased husband's medical records from January 12, 2015 to present.

A copy of the SPAR report is enclosed.

If you should have further questions in regards to this SPAR report please contact: Leah Finch, Acting Privacy Officer at 608-372-6144.

Sincerely,

Cheryl Starkey

Cheryl Starkey
Chief Health Information Management Section

Enclosure

Baer Thomas_record accessed report
DEVICE: HOME// Linux Telnet/SSH Right Margin: 80//
Sensitive Patient Access Report for JAN 12, 2015 to FEB 27, 2015 Page: 1
Run Date : FEB 27, 2015@10:29 Social Sec Num: XXXXXXXXXX
Patient Name: BAER,THOMAS P Date of Birth : JUL 18, 1940

USER	DATE ACCESSED	OPTION/PROTOCOL USED	INPATIENT
NUTTING, JULIE A RN	FEB 25, 2015@08:27	CPR5Chart version 1.	NO
LANE-BELCHER, TRACEY	FEB 26, 2015@12:46	CPR5Chart version 1.	NO
SEITZ, JAMES	FEB 25, 2015@14:30	Capri GUI (Broker)	NO
HAYDEN, JENELLE A RN	FEB 26, 2015@09:35	CPR5Chart version 1.	NO
HENDRICKSON, SCOTT D	FEB 27, 2015@08:03	CPR5Chart version 1.	NO
QUEZADA, JAIME	FEB 26, 2015@15:14	CPR5Chart version 1.	NO
LISI, ANY M	FEB 26, 2015@14:09	CPR5Chart version 1.	NO
PALAZZOLO, CHRISTINE	FEB 26, 2015@12:57:10	Expand Entry	NO
PALAZZOLO, CHRISTINE	FEB 26, 2015@12:57	Appointment Manageme	NO

Select Security Officer Menu Option:

[Print](#)*Attachment #3*[Close](#)**Re: [EXTERNAL] Questions & links**

From: Hensel, Stephanie (OIG) (Stephanie.Hensel@va.gov)
 Sent: Thu 3/12/15 2:07 PM
 To: Candace Baer (kitana6@hotmail.com)

Thank you for emailing. We will release our findings when we have finished our work. We are working as quickly as we can. Stephanie

From: Candace Baer
 Sent: Thursday, March 12, 2015 8:04 AM
 To: Hensel, Stephanie (OIG)
 Cc: ben@benjaminkrauselaw.com
 Subject: RE: [EXTERNAL] Questions & links

Hi Stephanie,

Tomorrow will mark 3 weeks since my mother and I sent you the questions below. We have not heard anything from you since we submitted my father's medical records on February 25, 2015. Could you give me a timeline as to when we can expect answers to any or all of our questions?

Thank you

Candace Delis

- > From: Stephanie.Hensel@va.gov
- > To: kitana6@hotmail.com
- > Date: Fri, 20 Feb 2015 15:49:09 -0600
- > Subject: Re: [EXTERNAL] Questions & links
- >
- > Thank you.
- >
- > From: Candace Baer
- > Sent: Friday, February 20, 2015 7:50 AM
- > To: Hensel, Stephanie (OIG)
- > Cc: ben@benjaminkrauselaw.com
- > Subject: [EXTERNAL] Questions & links

>
>
> HI Stephanie,
>
> Thank you for taking the time to listen to my mother and I yesterday. Below are a list of
questions we have. I have included the link to the news story, the comments are at the bottom
of the transcript - I've included 3 of the most troubling comments. Please let me know if you
have any further questions for us.
>
> Candace Delis
>
> 1) How long was the CT Scan machine out of order? Can we get a copy of the work order?
>
> 2) What caused the delay on Jan 12 that made the machine unavailable even at 4pm?
>
> 3) Was the facility helicopter out for maintenance, too? Can you get a copy of the flight
records?
>
> 4) According to the Tomah VA website, of the 94 doctors and nurses on staff, Dr. Patterson,
the doctor who treated my father, is the only one who is board certified in emergency
medicine. Why was he unaware of the symptoms of a stroke?
>
> 5) The symptoms of a stroke are:
> • Weakness or numbness or paralysis of the face, arm or leg on either or both sides of the
body
> • Difficulty speaking or understanding
> • Dizziness, loss of balance or an unexplained fall
> • Loss of vision, sudden blurring or decreased vision in one or both eyes
> • Headache, usually severe and abrupt onset or unexplained change in the pattern of
headaches
> • Difficulty swallowing
> My father had all of these after the first episode in the waiting room, and they are noted in
his records. Why did the staff not treat this as a YIA (mini-stroke) immediately? We were told
that since he "came out of it", that they would just put him into a room because they were
"very busy". I pleaded with them to do whatever tests they could because I felt he had
experienced a stroke. Why were my concerns dismissed when the symptoms were so obvious?
>
> 6) Why did Dr. Patterson wait until after the 2nd stroke to even suggest a CT scan? Had he
suggested it after the initial stroke, maybe my father could have been moved to a better
equipped facility more quickly.
>
> 7) Why wasn't the decision made to send my dad to Tomah Memorial?
>

- > 8) When we arrived at Gundersen, we were told that the clot busting drug should be administered within 1 hour of the first stroke symptoms by their neurosurgeon. Why didn't Dr. Patterson or the nursing staff treat my father's case with more urgency?
>
- > 9) Most people in Healthcare Facilities (including receptionists) are trained in Stroke Recognition and Response. They have badges that identify symptoms and have a Code Stroke protocols. Will the Tomah VA be trained in stroke treatment and prevention? Can I get a copy of VA training for stroke?
>
- > 10) Who is able to access my dad's medical records at this time? And for what reason? Our concern, based on public comments we have seen by people claiming to be VA employees, is that people/employees have been accessing his records unnecessarily. As we see it, this is a violation of the strict guidelines set forth by HIPAA, given the fact that my father is no longer a patient at the facility. We picked my dad's records up from the Tomah VA on February 5th, 2015. We see no reason for anyone to be accessing those records beyond that date, outside of the OIG for their investigation. We would think that the VA would frown on, or at the very least, discourage, it's employees from making disparaging and inflammatory remarks in a public forum toward a grieving family.
>
- > Here is the link: <http://www.wsaw.com/home/headlines/Marshfield-Family-Speaks-Out-Against-Tomah-VA-291985761.html?device=phone&c=y#PhotoSwipe1424005793506>
>
- > Here are three specific comments, two which come from someone who clearly identified themselves as an employee of the facility (Tomah RN) - I don't know how anyone other than an employee (or possibly a few patients) would know that it is only a 4 bed urgent care. We certainly did not know that. The same goes for the comment about it being a 99% psychiatric hospital:
>
- > Tomah RN • 4 days ago <<http://www.wsaw.com/home/headlines/Marshfield-Family-Speaks-Out-Against-Tomah-VA-291985761.html?device=phone&c=y#comment-1858076595>>
>
- > I wish the press would do some serious fact finding before they encourage articles like this. I understand how hard it is to lose someone you love, but this story is based on emotion and not fact. Ask Ms. Delis to release her father's medical records to the press, including those from GLH. I am the first to point fingers at Dr. Houlihan and his harem, and agree 100% with the allegations against him, but this story borders on slander. How many hospitals did they drive past that have ER's? only to come to a tiny 4 bed URGENT CARE? What services do UC's normally have access to? People need to get the facts before they make allegations that are totally false!
>
- >
- > Just be honest <<http://www.wsaw.com/home/headlines/Marshfield-Family-Speaks-Out-Against-Tomah-VA-291985761.html?device=phone&c=y#comment-1858240116>> • 4 days

ago <<http://www.wsaw.com/home/headlines/Marshfield-Family-Speaks-Out-Against-Tomah-VA-291985761.html?device=phone&c=y#comment-1858252964>>

>
> So you blame a 4 bed URGENT CARE facility for not having the medications only a hospital that has an ICU and specialists can have? You blame a little hospital that is 99% psychiatric for doing the very best they could with what they had to offer? Please be honest and tell the whole truth. I'm truly sorry you lost your father, the circumstances were crappy but no one's fault.

>
>
> Tomah RN <<http://www.wsaw.com/home/headlines/Marshfield-Family-Speaks-Out-Against-Tomah-VA-291985761.html?device=phone&c=y#comment-1858133749>> • 4 days
ago <<http://www.wsaw.com/home/headlines/Marshfield-Family-Speaks-Out-Against-Tomah-VA-291985761.html?device=phone&c=y#comment-1858226929>>

>
> No one is missing the point at all....ask away. Investigate with any and all internal or external agencies that want to- have at it. Speaking from personal experience, the VA goes above and beyond for our nations heros, as they should. The problem comes in when people expect more than a hospital such as Tomah can give.

> Just an FYI.....

>
> Tomah VA is a psychiatric/gero psychiatric facility with almost 300 beds, 15 are medical beds and there is a 4 bed urgent care. There is a small hospice unit and a rehab unit for veteran's who need help after surgery or after being sick until they are strong enough to go home.

> There are NO specialty services (other than mental health), No cardiology, no emergent neurology, and no MRI machines at the Tomah VA. CT machines break, computer programs go down. It's an unfortunate circumstance but I'm sure the Tomah VA is not the only place that has ever experienced this.

> Why come to a facility with so few services when you are so close to and drive by specialty services?

> I happily serve my veteran's every day with the utmost respect and take great pride in doing so, and I believe that 99% of the people I work with do and feel the same.

> VA care is free to the veteran's who qualify, yes, insurance pays first, if they have it. Some veteran's have co-pays but even those are minimal compared to outside insurance companies. I can promise you that if you seek outside medical care with private insurance, you WILL NOT receive the same level of care that you get at the VA. Insurance companies limit what they will pay for, such as lab tests, imaging studies and hospitalizations. The VA does not.

> The Tomah VA has come under scrutiny because of the brilliant David Houlihan aka "the candyman". Now people will be coming out of the woodwork trying to collect off of the ignorance and greed of one little man.

>

>

>

> 11) Will VA write a formal apology to my mother? When can we expect it?

[Print](#)*Attachment #4*[Close](#)

Review of Care at Tomah, Wisconsin VA Medical Center

From: **Wesley, George MD (OIG)** (George.Wesley@va.gov)
Sent: Fri 3/13/15 1:06 PM
To: 'kitana6@hotmail.com' (kitana6@hotmail.com)
Cc: Hensel, Stephanie (OIG) (Stephanie.Hensel@va.gov)

Dear Ms. Delis,

I am writing to respond to your email of yesterday (March 12, 2015) to Ms. Stephanie Hensel. I want to reassure you that OIG is working very hard to address the allegations made and concerns expressed about your late father's care at Tomah VAMC when we met with you and your mother via telephone on February 19, as well as in your February 20 via email.

At this time, I am simply unable provide you with further information, other than to again assure you that a tremendous amount of work is going into addressing the issues you and your mother raise.

Thank you very much.

Respectfully,

George Wesley

*Attachment #5***F A X**

Date:	Fri Mar 06 13:36 CST 2015
TO	
Fax Number:	16083721691
Name:	Tomah VA Privacy Officer
FROM	
Fax Number:	17155022788
Name:	Candace Delis
Company:	
Subject:	Request for Federal Records
Pages:	5

Notes:

Please see attached. Call 715-207-8168 with any questions.

Suzette Baer
Candace Baer-Delis
114 W. 4th
Marshfield, WI 54449

March 6, 2015

Tomah VA Privacy Officer

Re: Request for Federal Records

To Tomah VA Privacy Officer:

Consider this a FOIA/PA request concerning the investigation into the death of Thomas Baer. Please mail me responsive records on CD-ROM to my home address.

1. My daughter and I seek electronic mail records (Microsoft Exchange; Dept. of Veterans Affairs MX Servers) as outlined below from January 1, 2015 to present. The names of accounts is explained below. Please speak with the chief information officer at your location or VISN 12 to get instructions if you are uncertain how this works.
2. We seek copies of Thomas Baer's VistA file from January 1, 2015 to present.
3. We seek copies of his CPRS file from January 1, 2015 to present.
4. We seek copies of all other communications sent or received about this matter with Dept. of Veterans Affairs, Senator Tammy Baldwin's office, Senator Ron Johnson's office, or VA OIG related to investigation into the death of Thomas Baer or his living family members Suzette Baer or Candace Baer-Delis from January 1, 2015 to present.
5. We also seek the maintenance log and flight log of the helicopter from January 1, 2015 to present.
6. We also seek an updated SPAR report from January 1, 2015 to present.
7. We also seek the maintenance log and related documents of the CT Scan machine from January 1, 2014 to March 1, 2015. Please be sure to include copies of records back to through all of 2014.
8. We seek facility policies that will be explained below in effect January 1, 2015 to present.
9. We seek facility contracts with other medical facilities explained below in effect from January 1, 2015 to present.

USPS TRACKING # NONE

FOIA / Privacy Act Request

Veteran: **Thomas Baer**
Date: **03/06/2015**

Page 2 of 4

Here is a list of names of VA employees we seek copies of electronic mail communications related to Thomas Baer, Suzette Baer, Candace Baer-Delis and any reasonable deviation of our names including just the last name Baer:

1. Wendy Lyden
2. James R. Patterson
3. Sandra K. Hernandez
4. Jeffrey M. Olsen
5. Cynthia M. Clay
6. Julie A Nutting
7. Tracey Lane-Belcher
8. Jenelle A Hayden
9. James Seitz
10. Scott D. Hendrickson
11. Jaime Quezada
12. Amy M List
13. Christine Palazzolo
14. Stephanie Hensel
15. George Wesley
16. Leah Finch
17. Cheryl Starkey
18. Jane Mello
19. Amber J Schmidt
20. Timothy J O'Connell
21. Clement J Zablocki
22. Julie Burton
23. Joseph Lehner
24. Mario V. DeSanctis
25. Jeffrey L. Evanson

USPS TRACKING # NONE

FOIA / Privacy Act Request

Veteran: Thomas Baer
Date: 03/06/2015

Page 3 of 4

26. Katherine J. Pica

27. Carlo A. Piraino

We also seek copies of Federal records of certain hospital policies in effect at Tomah VA Medical Center from January 1, 2015 to present in all versions and updates since that date. Please conduct a broad search on relevant policies, directives, handbooks, etc., that provide guidance for the following:

- Urgent Care Policy
- Patient Intake Policy
- Radiology Policy
- CT Scan Repair Policy
- Care of Critically Ill Policy
- Patient Transfer Policy
- Helicopter Transfer Policy
- Progress Notes Policy (CPRS and/or VistA and/or Paper Notes)
- Stroke Policy

We also seek a copy of all contracts in effect at the time of Thomas Baer's admission to Tomah VA with Wisconsin hospitals for fee basis, non-VA health care including Marshfield Clinic, Gunderson Health System, Tomah Memorial Hospital.

I will pay reasonable fees associated with duplication of these records onto CD-ROM. Send the CD-ROM to the address in the header of this request, Suzette Baer, 114 W. 4th, Marshfield, WI 54449.

Please scan the records into PDF files and provide them in electronic form via CD ROM and charge reasonable duplication fees associated with it. **Please EXPEDITE THIS REQUEST as the records related to health care matters.**

Please note that this request for documents is being made pursuant to the Privacy Act, 5 U.S.C. § 552, and the Freedom of Information Act (FOIA), 5 U.S.C. § 552a, as well as 38 C.F.R. § 1.550 and 38 C.F.R. § 1.577. Your agency has a duty to satisfy this request within TWENTY (20) DAYS of the date of this request pursuant to 5 U.S.C. § 552 (a)(6)(A)(2)(i).

Additionally, although an extension of time to respond may be requested, it may only be granted for "unusual circumstances." "Predictable agency workload" is not typically considered

USPS TRACKING # NONE

FOIA / Privacy Act Request

Veteran: Thomas Baer
Date: 03/06/2015

Page 4 of 4

an unusual circumstance as stated in 5 U.S.C. § 552(a)(6)(C)(ii). Moreover, even to the extent that unusual circumstances could be demonstrated in this instance, the time limit for the extension is limited to "10 working days" pursuant to 38 C.F.R. § 1.553(d).

Please also be aware that your agency's failure to provide all records requested within twenty (20) business days may result in the filing of an administrative appeal with the office of the Secretary of the Department of Veterans Affairs pursuant to 38 C.F.R. § 1.557 and 5 U.S.C. § 552(a)(6)(A)(2)(ii), and potentially, the filing of a federal lawsuit to compel the production of the information.

This may subject your agency to contempt of court and a fine, including attorney fees and litigation expenses in compelling the production of this information pursuant to 38 U.S.C. § 552a(g)(1) of the Privacy Act, and 38 U.S.C. § 552(a)(4)(B) of FOIA. Thank you.

Sincerely,


Suzanne Baer Candace Baer-Delis
Suzanne Baer Candace Baer-Delis

Attachment #6
FAX

	Date: Tue Mar 17 09:52 CDT 2015
	TO
	Fax Number: 16083721108
	Name: Leah Finch/Cheryf Starkey
	FROM
	Fax Number: 17155022788
	Name: Candace Dals
	Company:
	Subject: Thomas Patrick Beer
	Pages: 6
Notes:	I have also attached the original fax confirmation from March 8th.

This Fax is Powered by SxD, Inc.

FAX

	Date: Tue Mar 17 09:55 CDT 2015
	TO
	Fax Number: 18083721691
	Name: Cheryl Starkey/Leah Finch
	FROM
	Fax Number: 17155022788
	Name: Candace Dalls
	Company:
	Subject: Thomas Patrick Baer
	Pages: 6
Notes:	
I have also attached a copy of the fax confirmation from March 6, 2015.	

This Fax is Powered by 8x8, Inc.

Attachment # 7

<input type="checkbox"/>		1-608-372-1691	+		Mar 17, 2015	9:48 AM
<input type="checkbox"/>		1-608-372-1108	+	✓ Delivered	Mar 17, 2015	9:45 AM
<input type="checkbox"/>		1-608-372-1691	+	✓ Delivered	Mar 6, 2015	1:29 PM
<input type="checkbox"/>						

STATEMENT OF JOHN D. DAIGH, JR., M.D., CPA
ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
BEFORE A JOINT FIELD HEARING OF
THE COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
AND
THE COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS
UNITED STATES SENATE
ON THE OPERATIONS OF THE TOMAH VA MEDICAL CENTER
TOMAH, WISCONSIN

MARCH 30, 2015

Messrs. Chairmen and Members of the Congress, thank you for the opportunity to testify today on the Office of Inspector General's (OIG) inspection of allegations related to the prescribing practices of staff at the Tomah VA Medical Center (VAMC), in Tomah, Wisconsin, conducted from October 2011 through March 2014. I am accompanied by Alan Mallinger, M.D., Senior Physician, Office of Healthcare Inspections. I will provide a brief summary of the OIG's work, which is outlined in the administrative closure that was posted on the OIG website on February 6, 2015.

BACKGROUND

In March 2011, the OIG Hotline received a complaint regarding prescription practices at the Tomah VAMC. After review, we referred the allegations to the Director, Veterans Integrated Service Network (VISN) 12, VA Great Lakes Health Care System, who has managerial oversight of the Tomah VAMC. A copy of this referral was also sent to the office of the Veterans Health Administration (VHA) Chief of Staff. The VISN 12 Director provided a detailed response to the allegations on June 22, 2011, that stated 16 allegations involving over 30 patients were unsubstantiated. The VISN 12 Director substantiated two allegations involving two patients. As a result of this review, the VISN Director initiated an action plan to:

- Review refill policies at Tomah VAMC.
- Review Tomah policies regarding lab testing of patients on narcotics.
- Evaluate practice trends and approaches to pain to ensure the needed variety of pain approaches is available to Tomah patients.
- Work with the Chief of Staff to evaluate pain approaches and the effectiveness of such.

Based on the VISN 12 Director's fact-finding efforts and commitment to take corrective action, we closed the complaint.

HEALTHCARE INSPECTION – ALLEGED INAPPROPRIATE PRESCRIBING OF CONTROLLED SUBSTANCES AND ALLEGED ABUSE OF AUTHORITY, TOMAH VA MEDICAL CENTER, TOMAH, WISCONSIN

On August 25, 2011, the OIG Hotline received a new anonymous complaint with similar allegations, including a statement that the same letter had been sent to all Wisconsin Senators and Representatives. On September 29, 2011, Representative Ron Kind forwarded the same complaint to the OIG Hotline. On October 7, 2011, the Office of Healthcare Inspections accepted the case for review. Over the course of the next 3 years, the OIG Office of Healthcare Inspections conducted an extensive inspection of the allegations involving the OIG's Office of Investigations, the Drug Enforcement Agency, and Tomah and Milwaukee municipal police to determine if there was evidence of narcotic abuse at the Tomah VAMC. We reviewed patient medical records, protected peer reviews of providers' practice, and pharmacy records. We conducted an undercover surveillance operation and reviewed email messages and associated files originating from 17 individuals. We interviewed at that time current and former VA employees and conducted a site visit that included touring the outpatient pharmacy to assess security.

We could not substantiate the majority of allegations made in the complaints that the OIG received. Although the allegations dealing with general overuse of narcotics at the facility may have had some merit, they did not constitute proof of wrongdoing. We did not find any conclusive evidence affirming criminal activity, gross clinical incompetence or negligence, or administrative practices that were illegal or violated personnel policies. We administratively closed the inspection on March 14, 2014. VHA Central Office senior officials were advised 3 days earlier about the Tomah inspection. While the decision to close this inspection administratively has since been questioned, at the time we believed that given the totality of the facts—paramount of which was that the allegations were not substantiated and the impact disclosure of unfounded allegations could have on an individual's reputation and privacy—an administrative closure was appropriate.

We noted several issues of concern and made suggestions to address these concerns to the VAMC Director and the VISN 12 Director. We conducted a telephone briefing with the Tomah VAMC Director, VISN 12 Quality Management Officer, and the Organizational Improvement Analyst for the Tomah VAMC on July 3, 2014; and met in person with the VISN 12 Director on July 16, 2014, to discuss the following suggestions:

- The Facility Director should implement a vehicle by which clinicians and staff can openly and constructively communicate concerns and rationale when disagreements arise concerning dispensing of opioid prescriptions.
- The Facility Director should review the reporting structure in the context of safeguarding bi-directional clinical discourse from actual or perceived administrative constraint.

- The Facility Director should ensure development of guidance, parameters, processes, or a specialty clinic-based mechanism to assist clinicians and staff with managing complex patients requesting early opioid refills.
- The Facility Director should consider some variant of the tumor board model as one potential avenue by which to foster collaborative interdisciplinary management when presented with very complex clinical pain cases.
- The VISN should conduct further evaluation and monitoring of relative and case-specific opioid prescribing at Tomah VAMC on both a facility and individual clinician level.

The OIG currently has several inspections ongoing at the Tomah VAMC concerning allegations of poor patient care. When our work is completed, we will publish the results on our website. However, due to privacy concerns and other restrictions on the release of protected information, those reports will not mention names and sensitive information may be redacted or omitted. I can assure you that the OIG's review will be a comprehensive review of the facts based on a thorough review of all information available.

We have included a list of reviews conducted by the OIG since 2011 related to opioid prescribing practices, including a national review issued on May 14, 2014, *Healthcare Inspection – VA Patterns of Dispensing Take-Home Opioids and Monitoring Patients of Opioid Therapy*. In this report, we found that VA was not following its own policies and procedures in six key areas: acetaminophen prescription practices; follow-up evaluations of patients on take-home opioids; concurrent substance use treatment with urine drug tests; prescribing and dispensing of benzodiazepines concurrently with opioids; routine and random urine drug tests prior to and during take-home opioid therapy; and medication reconciliation. We note that VA has taken actions to implement a number of the recommendations in this report, but VA must be vigilant in monitoring facility compliance with opioid prescription policies and completing outstanding recommendations.

CONCLUSION

The OIG's healthcare inspection at the Tomah VAMC was painstaking and exhaustive. At the end of a 2 and ½ year review, we concluded that opioid prescribing practices of some Tomah VAMC staff were at the outer boundary of acceptable prescribing practice, found no evidence that illegal activity was occurring, and closed the inspection administratively. This in no way should suggest that we are unconcerned about the proliferation of opioid prescribing at the Tomah VAMC or other VHA facilities. In fact, the OIG has been concerned for some time with opioid prescribing practices across the VHA health care system and in May 2014 made six recommendations in our national report for corrective actions. We are committed to completing our ongoing healthcare inspections at the Tomah VAMC with great care and diligence, and will provide our results to VA and Congress as soon as we are completed.

APPENDIX A

**VA Office of Inspector General
Reporting on Opioid Prescription Practices**

December 9, 2014 Alleged Inappropriate Opioid Prescribing Practices, Chillicothe VA Medical Center, Chillicothe, Ohio
<http://www.va.gov/oig/pubs/VAOIG-14-00351-53.pdf>

July 17, 2014 Quality of Care and Staff Safety Concerns at the Huntsville Community Based Outpatient Clinic, Huntsville, Alabama
<http://www.va.gov/oig/pubs/VAOIG-14-01322-215.pdf>

June 25, 2014 Medication Management Issues in a High Risk Patient, Tuscaloosa VA Medical Center, Tuscaloosa, Alabama
<http://www.va.gov/oig/pubs/VAOIG-13-02665-197.pdf>

June 9, 2014 Quality of Care Concerns Hospice/Palliative Care Program, Western New York Healthcare System, Buffalo, New York
www.va.gov/oig/pubs/VAOIG-13-04195-180.pdf

May 14, 2014 VA Patterns of Dispensing Take-Home Opioids and Monitoring Patients on Opioid Therapy
<http://www.va.gov/oig/pubs/VAOIG-14-00895-163.pdf>

November 7, 2013 Alleged Improper Opioid Prescription Renewal Practices, San Francisco VA Medical Center, San Francisco, California
<http://www.va.gov/oig/pubs/VAOIG-13-00133-12.pdf>

August 21, 2012 Management of Chronic Opioid Therapy at a VA Maine Healthcare System Community Based Outpatient Clinic
<http://www.va.gov/oig/pubs/VAOIG-12-01872-258.pdf>

August 10, 2012 Patient's Medication Management, Lincoln Community Based Outpatient Clinic, Lincoln, Nebraska
<http://www.va.gov/oig/pubs/VAOIG-12-02274-244.pdf>

August 19, 2011 Alleged Improper Care and Prescribing Practices for a Veteran, Tyler VA Primary Care Clinic Tyler, Texas
<http://www.va.gov/oig/54/reports/VAOIG-11-01996-253.pdf>

June 15, 2011 Prescribing Practices in the Pain Management Clinic at John D. Dingell VA Medical Center, Detroit, Michigan
<http://www.va.gov/oig/54/reports/VAOIG-11-00057-195.pdf>

STATEMENT OF JOHN D. DAIGH, JR., M.D., CPA
ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
BEFORE A JOINT FIELD HEARING OF
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We have included a list of reviews conducted by the OIG since 2011 related to opioid prescribing practices, including a national review issued on May 14, 2014, *Healthcare Inspection – VA Patterns of Dispensing Take-Home Opioids and Monitoring Patients of Opioid Therapy*. In this report, we found that VA was not following its own policies and procedures in six key areas: acetaminophen prescription practices; follow-up evaluations of patients on take-home opioids; concurrent substance use treatment with urine drug tests; prescribing and dispensing of benzodiazepines concurrently with opioids; routine and random urine drug tests prior to and during take-home opioid therapy; and medication reconciliation. We note that VA has taken actions to implement a number of the recommendations in this report, but VA must be vigilant in monitoring facility compliance with opioid prescription policies and completing outstanding recommendations.

CONCLUSION

The OIG's healthcare inspection at the Tomah VAMC was painstaking and exhaustive. At the end of a 2 and ½ year review, we concluded that opioid prescribing practices of some Tomah VAMC staff were at the outer boundary of acceptable prescribing practice, found no evidence that illegal activity was occurring, and closed the inspection administratively. This in no way should suggest that we are unconcerned about the proliferation of opioid prescribing at the Tomah VAMC or other VHA facilities. In fact, the OIG has been concerned for some time with opioid prescribing practices across the VHA health care system and in May 2014 made six recommendations in our national report for corrective actions. We are committed to completing our ongoing healthcare inspections at the Tomah VAMC with great care and diligence, and will provide our results to VA and Congress as soon as we are completed.

APPENDIX A**VA Office of Inspector General
Reporting on Opioid Prescription Practices**

December 9, 2014 Alleged Inappropriate Opioid Prescribing Practices, Chillicothe VA Medical Center, Chillicothe, Ohio
<http://www.va.gov/oig/pubs/VAOIG-14-00351-53.pdf>

July 17, 2014 Quality of Care and Staff Safety Concerns at the Huntsville Community Based Outpatient Clinic, Huntsville, Alabama
<http://www.va.gov/oig/pubs/VAOIG-14-01322-215.pdf>

June 25, 2014 Medication Management Issues in a High Risk Patient, Tuscaloosa VA Medical Center, Tuscaloosa, Alabama
<http://www.va.gov/oig/pubs/VAOIG-13-02665-197.pdf>

June 9, 2014 Quality of Care Concerns Hospice/Palliative Care Program, Western New York Healthcare System, Buffalo, New York
www.va.gov/oig/pubs/VAOIG-13-04195-180.pdf

May 14, 2014 VA Patterns of Dispensing Take-Home Opioids and Monitoring Patients on Opioid Therapy
<http://www.va.gov/oig/pubs/VAOIG-14-00895-163.pdf>

November 7, 2013 Alleged Improper Opioid Prescription Renewal Practices, San Francisco VA Medical Center, San Francisco, California
<http://www.va.gov/oig/pubs/VAOIG-13-00133-12.pdf>

August 21, 2012 Management of Chronic Opioid Therapy at a VA Maine Healthcare System Community Based Outpatient Clinic
<http://www.va.gov/oig/pubs/VAOIG-12-01872-258.pdf>

August 10, 2012 Patient's Medication Management, Lincoln Community Based Outpatient Clinic, Lincoln, Nebraska
<http://www.va.gov/oig/pubs/VAOIG-12-02274-244.pdf>

August 19, 2011 Alleged Improper Care and Prescribing Practices for a Veteran, Tyler VA Primary Care Clinic Tyler, Texas
<http://www.va.gov/oig/54/reports/VAOIG-11-01996-253.pdf>

June 15, 2011 Prescribing Practices in the Pain Management Clinic at John D. Dingell VA Medical Center, Detroit, Michigan
<http://www.va.gov/oig/54/reports/VAOIG-11-00057-195.pdf>

STATEMENT OF
CAROLYN CLANCY, M.D.
INTERIM UNDER SECRETARY FOR HEALTH
VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

MARCH 30, 2015

Good morning, Chairman Johnson, Chairman Miller, and Members of the Committee. Thank you for the opportunity to participate in this hearing and to discuss the quality of care at the Tomah VA Medical Center. I am accompanied today by Renee Oshinski, Veterans Integrated Service Network (VISN) 12 Acting Network Director, and Mario DeSanctis, Director of the Tomah VA Medical Center.

At VA, we care deeply for every Veteran we have the privilege to serve. One of our most important priorities is to keep our patients free from harm while receiving care at our facilities. I am saddened by any adverse consequence that a Veteran might experience while in, or as a result of, our care, and I would like to express my sincere sympathy to the families of those Veterans we have lost here in Tomah.

VA is committed to providing the highest quality care, but it is not perfect and there are always areas that need improvement. We can, and we must do better. The identification, mitigation, and prevention of vulnerabilities within our health care system are ongoing processes. Where challenges occur, VA takes direct action to review each incident and puts in place processes to correct system issues and improve quality of care. We incorporate lessons learned to avoid and mitigate future incidents throughout the entire health care system. VA also takes any allegations about patient care or employee misconduct very seriously and will hold employees accountable if there is wrongdoing.

Chronic Pain across the Nation

Chronic pain affects the Veteran population, but this is not an issue limited to Veterans. Chronic pain is a national public health problem as outlined in the 2011 study by the Institute of Medicine (IOM). At least 100 million Americans suffer from some

form of chronic pain. The IOM study describes in detail many concerns of pain management, including system-wide deficits in the training of our Nation's health care professionals in pain management; the problems caused by a fragmented health care system; the general public's lack of knowledge about pain leading to inadequate self-management; and the need for care planning that is personalized for the individual patient. While about 30 percent of the Nation's adult population experiences chronic pain, the problem of chronic pain in VA is even more daunting, with almost 60 percent of returning Veterans from the Middle East and more than 50 percent of older Veterans in the VA health care system living with some form of chronic pain. The treatment of Veterans' pain is often very complex. Many of our Veterans have survived severe battlefield injuries, some repeated, resulting in life-long moderate to severe pain related to damage to their musculoskeletal system and permanent nerve damage, which cannot only impact their physical abilities but also impact their emotional health and brain structures.

VA's Progress in Pain Management

Chronic pain management is challenging for Veterans and clinicians -- VA continues to focus on identifying Veteran-centric approaches that can be tailored to individual needs that may also include physician therapy, acupuncture, chiropractic treatments, and other modalities in addition to medications. Opioids are an effective treatment, but their use requires constant vigilance to minimize risks and adverse effects. VA launched a system-wide OSI in October 2013, and has seen significant improvement in the use of opioids as discussed later in the testimony. Most recently, in March 2015, we launched the new Opioid Therapy Risk Report tool which provides detailed information on the risk status of Veterans taking opioids to assist VA primary care clinicians with pain management treatment plans. This tool is a core component of our reinvigorated focus on patient safety and effectiveness.

VA's own data, as well as the peer-reviewed medical literature, suggest that VA is making progress relative to the rest of the Nation. In December 2014, an independent study by RTI International health services researcher, Mark Edlund, MD, PhD and colleagues, supported by a grant from the National Institute of Drug Abuse,

was published in the journal *PAIN*¹ (the premier research publication in the field of pain management. This study, using VHA pharmacy and administrative data, reviewed the duration of opioid therapy, the median daily dose of opioids, and the use of opioids in Veterans with substance use disorders and co-morbid chronic non-cancer pain. Dr. Edlund and his colleagues found that:

- First, half of all Veterans receiving opioids for chronic non-cancer pain, are receiving them short-term (i.e.: for less than 90 days per year);
- Second, the daily opioid dose in VA is generally modest, with a median of 20 Morphine Equivalent Daily Dose (MEDD), which is considered low risk; and
- Third, the use of high-volume opioids (in terms of total annual dose) is not increased in VA patients with substance use disorders as has been found to be the case in non-VA patients.

Dr. Edlund and the other authors concluded "this suggests appropriate vigilance at VA, which may be facilitated by a transparent and universal electronic medical record." Although it is good to have this information, a confirmation of our efforts for several years, starting with the "high alert" opioid initiative in 2008 and multiple educational offerings, by no means is VA's work finished. In fact, although we are well along in implementing our plan, VA is also working with other Federal agencies and VAMC experts to implement the National Institutes of Health-Department of Health and Human Services National Pain Strategy, an outgrowth of the IOM study, which recommends a transformation in the education of physicians and other health care professionals in pain management. By virtue of VA's central national role in medical student education and residency training of primary care physicians and providers, we will be playing a major role in this national effort. But we have already started with our robust education and training programs for primary care, such as SCAN-ECHO, Mini-residency, Community of Practice calls, two JIF training programs with DoD, and dissemination of the OSI Toolkit.

¹ Edlund MJ et al, Patterns of opioid use for chronic noncancer pain in the Veterans Health Administration from 2009 to 2011. *PAIN* 155(2014) 2337-2343

The Opioid Safety Initiative

The OSI was chartered by the Under Secretary for Health in August 2012. The OSI was piloted in several VISNs. Based on those results of the pilot programs, OSI was implemented nationwide in August 2013. The OSI objective is to make the totality of opioid use visible at all levels in the organization. It includes key clinical indicators such as the number of unique pharmacy patients dispensed an opioid, unique patients on long-term opioids who receive a urine drug screen, the number of patients receiving an opioid and a benzodiazepine (which puts them at a higher risk of adverse events), and the average MEDD of opioids. Results of key clinical metrics for VHA measured by the OSI from Quarter 4, Fiscal Year 2012 (beginning in July 2012) to Quarter 1, Fiscal Year 2015 (ending in December 2014) are:

- 91,614 (13%) fewer patients receiving opioids (679,376 => 587,762);
- 29,281 (24%) fewer patients receiving opioids and benzodiazepines together (122,633 => 93,352) ;
- 71,255 more patients on opioids that have had a urine drug screen to help guide treatment decisions(160,601 => 231,856);
- 67,466 (15%) fewer patients on long-term opioid therapy (438,329 => 370,863);
- The overall dosage of opioids is decreasing in the VA system as 10,143 (17%) fewer patients are receiving greater than or equal to 100 MEDD (59,499 => 49,356); and
- The desired results of OSI have been achieved during a time that VA has seen an overall growth of 75,843 (2%) patients who have utilized VA outpatient pharmacy services (3,959,852 => 4,035,695).

The changes in prescribing and consumption are occurring at a modest pace and the OSI dashboard metrics indicate the overall trends are moving in the desired direction. OSI will be implemented in a cautious and measured way to give VA time to build the infrastructure and processes necessary to allow VA clinicians to incorporate new pain management strategies into their treatment approaches. A measured process will also give VA patients time to adjust to new treatment options and to mitigate any patient dissatisfaction that may accompany these changes.

While these changes may appear to be modest given the size of the VA patient population, they signal an important trend in VA's use of opioids. VA expects this trend to continue as it renews its efforts to promote safe and effective pharmacologic and non-pharmacologic pain management therapies. Very effective programs yielding significant results have been identified (e.g., Minneapolis, Tampa), and are being studied as strong practice leaders.

State Prescription Drug Monitoring Programs

Another risk management approach to support the Veterans' and public's safety is VHA participation in state Prescription Drug Monitoring Programs (PDMP). During this administration, VA implemented a regulatory change to enable VA prescribers to access information contained in these databases. These programs, with appropriate health privacy protections, allow for the interaction between VA and state databases, so that providers can identify potentially vulnerable at-risk individuals. VA providers who register with the State PDMP can now access the state PDMP for information on prescribing and dispensing of controlled substances to Veterans outside the VA health care system. When fully deployed, non-VA providers will also be able to identify their patients who may be receiving controlled substances from VA. VA is working on policy to require PDMP use by controlled substance prescribers in accord with the Administration's 2011 Prescription Drug Abuse Prevention Plan recommendations. Participation in PDMPs will enable providers to identify patients who have received non-VA prescriptions for controlled substances, which in turn offers greater opportunity to discuss the effectiveness of these non-VA prescriptions in treating their pain or symptoms. More importantly, information available through these programs will help both VA and non-VA providers to prevent harm to patients that could occur if the provider was unaware that a controlled substance medication had been prescribed elsewhere already.

Opioid Therapy Risk Report

In conjunction with the OSI, a population-based provider report and feedback tool has recently been developed and is now available to all primary care providers and their teams. This report, easily accessible through a direct link in the electronic health record, assists the PACTs to manage their entire panel of patients prescribed pharmacotherapy for acute or chronic pain; this tool makes it easy to ensure Veterans receiving safe, quality care. This resource provides a quick but thorough assessment of their patients' opioid risk for adverse outcomes. Included in the report is the current opioid dose, concomitant use of benzodiazepines, and presence of associated high-risk diagnoses such as substance use disorder or posttraumatic stress disorder. Urine drug screens, recent mental health and primary care visits, and the presence of a signed opioid agreement are also tracked. By clicking on the patient's name in the report, the provider can immediately pull up graphs showing the relationship between the patient's opioid dose and pain score over the past 12 months. This tabular and graphical information alerts the provider to situations where closer follow up may be needed or to settings where opioid withdrawal or dose reduction may be opportune. To better inform decision making, links to practical pain presentations and opioid clinical guidelines are also embedded.

This report was developed in late 2014 and released in early 2015. A comprehensive training program for primary care was launched in February 2015 reaching over 2,000 PACT providers and their teams. This tool will also assist in the monitoring of opioid prescribing behavior of our primary care workforce over time.

Complementary and Integrative Medicine

The number one strategic goal of VHA is "to provide Veterans personalized, proactive, patient-driven health care." Integrative Health includes Complementary and Alternative Medicine approaches, provides a framework that aligns with personalized, proactive, patient-driven care. There is growing evidence in the effectiveness of non-pharmacological approaches as part of a comprehensive care plan for chronic pain which includes acupuncture, massage, yoga and spinal manipulation. VA is establishing the Integrative Health Coordinating Center (IHCC) within the Office of Patient-Centered

Care and Cultural Transformation to build the infrastructure (e.g. establishing new occupations) to support the delivery of these services.

VA's Opioid Education and Naloxone Distribution Program

In certain situations, opioids are the best choice for pain. Naloxone is an antidote to respiratory depression which can cause fatal overdose. With opioid use, risks are involved, and VA is taking precautionary steps to mitigate these risks. In May 2014, a VHA team developed and implemented VA's Overdose Education and Naloxone Distribution (OEND) program. Although VA's national OEND program is less than 1 year old, as of March 8, 2015, over 2,400 naloxone kit prescriptions have been dispensed to at-risk Veterans throughout the United States. As a result of these efforts, 33 individuals' life-threatening opioid overdoses were reversed as a direct result of the OEND program.

Tomah VA Medical Center

VA is actively reviewing allegations of improper opioid prescribing practices and retaliatory behavior at the Tomah VAMC.

Accountability and allegations of misconduct by employees are taken seriously. On January 15, 2015, a physician and nurse practitioner of greatest interest were relieved of their clinical care duties and the ability to prescribe any medications pending the outcome of all investigations. In response to whistleblower allegations of unsafe clinical care and prohibited personnel practices at the Tomah VAMC, on January 23, 2015, I charged a clinical review team to assess practice patterns, controlled substance prescribing habits, and administrative interactions between subordinates and clinical leadership related to opioid prescribing practices. The clinical review team was comprised of subject matter experts in mental health, pain management, pharmacy, and addictive disorders. The team completed the on-site portion of the review during the week of January 27, 2015, and completed phase one on February 26, 2015.

On March 10, 2015, the VA released key findings and recommendations of its initial clinical review into opioid prescription practices at the Tomah VA Medical Center.

The team made specific findings relating to overall opioid utilization at Tomah and found that an apparent culture of fear at the facility compromised patient care and impacted staff satisfaction and morale. Based on these preliminary findings, the team recommended that VA consider a more in-depth evaluation of the clinical and administrative practices at the Tomah VAMC. Additional cases were brought to the review team's attention, and a second in-depth clinical review being conducted by Lumetra, an external quality improvement organization, began on March 11, 2015. It will be completed within 30 days. Investigators from the independent VA Office of Inspector General and the Department of Justice's Drug Enforcement Agency have also been on site.

We are deeply concerned and distressed about the allegations that employees who sought to report deficiencies at the Tomah VAMC were either ignored, or worse, intimidated into silence. VA will not tolerate an environment where intimidation or suppression of concerns occurs. An administrative review team from VA's Office of Accountability Review (OAR) is continuing to look at allegations of retaliation against employees and other accountability issues related to Tomah VAMC leadership.

Both the internal VHA clinical review and Lumetra's in depth review, are confidential under 38 United States Code § 5705 and the implementing regulations. However, we can provide information on the broad themes noted during the VHA clinical review. The team identified patient safety concerns for some patients at Tomah based on opioid prescribing practices outside generally-accepted standards of care. Currently, certain personnel have been detailed out of patient care areas, and their prescribing privileges have been suspended during the ongoing investigations.

In response to the allegations and in order to create a more transparent culture and improve communication with VAMC employees, medical center leadership has taken a number of actions to include town hall meetings, supervisory forums, and expanded all employee communications. The focus of these actions were designed to provide staff support and guidance on how employees can directly and confidentially contact and communicate with the team conducting the investigations. In addition to actions taken to address culture and communication, Tomah initiated a number of actions to address opioid/pain management issues. Providers transitioned to using an

expanded urine drug screen, and facility clinical leadership is updating their pain management policies. Electronic patient record tools for providers are being deployed nationally. This will make pain management information more easily accessible during patient visits. As mentioned previously, prescribers can offer naloxone to patients and their families or caregivers to mitigate risk for overdose, as appropriate

The current situation in Tomah is unfortunate, but I want to acknowledge the many dedicated staff members, nurses and doctors, who are bearing the brunt of these issues. We rely on their concern for care and recognize the toll this situation is taking on them and the Tomah Veteran community.

Conclusion

In conclusion, we are continuing to investigate the situation at the Tomah VAMC and will update you on our findings. We at the Department take any concerns regarding the safety of our patients very seriously. Therefore, the safety and continued care of our Veterans is our focus throughout this situation. At VA, we depend on the service of employees and leaders who place the interests of Veterans above and beyond self-interest. Accountability, delivering results, and honesty are key to serving our Veterans. If employee misconduct is identified, VA will take appropriate action and hold those responsible accountable. These investigations are an opportunity to get to the bottom of any issues so that moving forward, these actions are not repeated elsewhere.

Mr. Chairman, we appreciate this Committee's support and encouragement in identifying and resolving challenges. My colleagues and I are prepared to respond to any questions you or the Committee may have.



Member AFL-CIO

American Federation of Government Employees
Affiliated with AFL-CIO
Local 0007
V.A. Medical Center
Tomah, WI 54660

STATEMENT FOR THE RECORD OF
LIN ELLINGHUYSEN, PRESIDENT, LOCAL 0007
THE AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO
TOMAH VA MEDICAL CENTER

JOINT HEARING OF
THE COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS OF THE U.S.
SENATE AND THE COMMITTEE ON VETERANS' AFFAIRS OF THE U.S. HOUSE OF
REPRESENTATIVES

TOMAH VAMC: EXAMINING QUALITY, ACCESS, AND A CULTURE OF OVER-RELIANCE ON HIGH-RISK MEDICATIONS

MARCH 30, 2015

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TOMAH VAMC: EXAMINING QUALITY, ACCESS, AND A CULTURE OF OVER-RELIANCE ON HIGH-RISK MEDICATIONS

MARCH 30, 2015

On behalf of Local 0007 of the American Federation of Government Employees, AFL-CIO (AFGE), which represents the front line employees at the Tomah VA Medical Center, I want to thank the Chairmen, Ranking Members and Members of the Senate Homeland Security and Governmental Affairs Committee and the House Committee on Veterans' Affairs for holding this hearing on overprescribing of high dosages of opioids.

AFGE 0007 represents approximately 850 medical and mental health professionals and support personnel providing direct patient care at the Tomah VA Medical Center main campus, and outreach clinics in Wisconsin Rapids, Wausau, Lacrosse and Owens. I have worked as a registered nurse at the Tomah VA for 29 years and I have been in a union leadership role at Local 0007 for the past 8 years.

AFGE Local 0007 has been in the forefront of the battle for increased veterans' safety and for a workplace free from oppression of those who speak out for safe, quality patient care. We have waged a long, hard fight to protect veterans by representing employees who have expressed concerns over the prescribing practices of Tomah's Chief of Staff, Dr. David Houlihan who ordered what appeared to many to be excessively high levels of opioids for veterans.

As a result of the many critical reports from AFGE Local 0007 and the front line employees we represent, we have been able to assist Congress, the VA Office of the Inspector General (OIG) and local law enforcement in their efforts to combat the high usage of addictive medications and reported diversion of drugs which have had devastating results for veterans, as well as employees who so bravely questioned this improper care.

AFGE 0007's persistent fact finding and unyielding requests for assistance and change have aided numerous investigations of the actions that placed veterans in harm's way. Additionally, the Union has represented several employees who were wrongfully removed from

employment due to their courageous questioning of opioid's adverse effects upon the veteran patients, in particular, the adverse impact of these prescribing practices on the ability of veterans to engage in their assigned therapies as well as accidents resulting from the decreased level of alertness caused by the ingestion of too many opioids combined with several other drugs.

The employees who chose to speak up and save veterans' lives could only do so because union officials were able to safely speak up on their behalf to protect them from management reprisal that violated federal law, VA policy and our collective bargaining agreement.

The front line employees we represent who come to work every day dedicated to providing veterans with the care they deserve and earned continuously confront a culture that punishes those who voice concerns for patient care. Instead of "See something; Say Something," Tomah VA's management appears to be indoctrinating the employees with "See Something; Shut Up!" As a result, most of the front line employees who witnessed patient harm, including the ordering of large quantities of medications by Dr. Houlihan, faced termination of their employment. Other employees who spoke up to protect veterans made the difficult decision to resign because they found they could not work at the Tomah VA and participate in what they viewed as the practice of ordering unwarranted high dosages of medications.

We continue to see a steady exodus of health care professionals with valuable experience and expertise from the Tomah VA because of this oppressive workplace and corrosive culture. The majority of clinicians who have recently left the Tomah VA have sought transfers to other VA facilities where they will be able to continue to provide veterans with the specialized, expert care they deserve in a more conducive environment free of reprisal and harsh autocratic management practices.

The most vulnerable employees in this type of destructive workplace culture are those with temporary appointments and recent hires still on probationary status because they have very limited protections against retaliatory terminations, suspensions and other unwarranted personnel actions. Management has targeted these employees with the fewest rights to set an example for other employees with permanent status which sends a strong signal as to what will happen to them should they decide to speak up or disagree with care given to veterans.

One of the battles that AFGE 0007 waged against management on behalf of a brave employee who questioned Dr. Houlihan's prescribing practices was particularly difficult. Dr. Christopher Kirkpatrick was a new psychologist at the Tomah VA who had a temporary appointment. He was required to obtain a minimum number of supervisory approved clinical hours, take the State Boards and become licensed within the first two years of his appointment. Management removed Dr. Kirkpatrick ten months after he was hired to work at the Tomah VA because he had questioned the large amounts of narcotics ordered and given to the patients in the PTSD and the Substance Abuse programs. Dr. Kirkpatrick had informed the proper chain of command that he was having difficulty treating the patients in therapy sessions because they

were unable to be alert and engage in therapy due to his concern over what appeared to be possible overmedication. Apparently, his chain of command informed Dr. David Houlihan, Chief of Staff, who did not appear to correct or properly investigate the problem, and was reportedly angry that the issue was even raised. Another incident which prompted Dr. Kirkpatrick's termination involved a veteran who threatened to do great harm to him. As a result of the veteran's threat, Dr. Kirkpatrick documented the threat in the proper manner as the agency directed. The treatment team had informed Dr. Kirkpatrick of their decision to discharge the patient due to his violent threat but apparently Dr. Houlihan overrode that decision. Dr. Kirkpatrick documented each step of what occurred. As a result, a Program Director at that time informed Dr. Kirkpatrick that she "wished he had not done that [documentation]." Subsequently, Dr. Kirkpatrick was fired.

Clearly, Dr. Kirkpatrick, a newly graduated Psychology major with a doctorate degree, had tried to do the right thing. He had informed his superiors that he was concerned about dealing with the complexities of some of the patients assigned to him and their medication levels and had asked for additional support and relief. Tragically, his superiors responded with silence to his quite reasonable concerns, and then terminated him. On the day Dr. Kirkpatrick was fired, he came to me to ask for the union's assistance which I provided. He also asked that the medical center develop a better support system so that others would not have to go through what he experienced at the Tomah VA. As a temporary employee, Dr. Kirkpatrick had no right to independent third party review of his termination or statutory appeal rights requiring management to show just cause for his removal. As a result, after receiving what appeared to be an unfair termination from the Tomah VA, which would clearly affect his ability to find new employment in his field, and after failing to receive any support from management as to his concerns for patient care, Dr. Kirkpatrick went home that day and committed suicide at the age of 38.

In Dr. Kirkpatrick's memory and in support of all VA employees who work in highly stressful positions providing medical and mental health care to veterans, AFGE Local 0007 offers the following recommendations:

- ↳ We urge Congress to mandate the development of a comprehensive support system for VA medical and mental health care professionals, that provide needed consultation services with trained professionals as part of their employment, and not to be seen as private treatment. These support services and consultations must maintain strict confidentiality. Currently, all that is offered at the Tomah VA are one or two sessions with a VA provided counselor; after that, employees are left to manage these very intense job duties on their own without time to debrief, refresh or regroup.
- ↳ We also request that lawmakers investigate the pervasive use of extended temporary appointments within the VA health care workforce, and the abusive use of terminations and other personnel actions against probationary employees, and mandate additional protections, both statutory and administrative, for these most vulnerable employees who pay the heaviest price when they question the current way of doing things.

↳AFGE Local 0007 recommends that lawmakers amend current law to extend the jurisdiction of the Office of Special Counsel (OSC) to cover all federal employees, including VA health care employees appointed under Title 38. In the VA health care system, the vast majority of employees are under Title 38, not Title 5, and therefore do not have many of the same rights to appeal management reprisal and other prohibited personnel practices to the OSC.

↳We also urge Congress to take steps to ensure greater accountability for VA front line managers, mid-level managers and upper management who engage in retaliation against whistleblowers and other front line employees who speak up for veterans' needs.

↳In addition, we urge Congress to review the current reporting structure for the Chief of Police at VA Medical Centers. Currently, they report to the Medical Center Director, rather than a separate entity that can address mismanagement or staff concerns without interference, such as the alleged illegal drug activity at Tomah.

↳Finally, AFGE Local 0007 recommends Congressional action to put in place checks and balances that ensure the safe ordering of opioids and development of guidelines for the safe combining of opioids with other addictive drugs to keep our veterans safe.

Thank you for the opportunity to present the views of AFGE Local 0007 and the front line VA employees we represent on this very important matter.



Department of Wisconsin

*STATEMENT OF
ABERT W. LABELLE, JR.
DAV WISCONSIN LEGISLATIVE DIRECTOR
AND TOMAH VA PATIENT
BEFORE
SLOAN D. GIBSON, IV
OFFICE OF THE DEPUTY SECRETARY
UNITED STATES DEPARTMENT OF VETERANS AFFAIRS (VA)
AT TOMAH VA MEDICAL CENTER
MARCH 10, 2015
AND SUBMITTED AS AMENDED TO THE COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS
UNITED STATES SENATE
APRIL 3, 2015*

VA Deputy Secretary Gibson,

Thank you for the opportunity to speak today as a patient of Tomah VA and as Disabled American Veterans (DAV) Wisconsin Legislative Director.

Feedback received from veterans by me and DAV Wisconsin is anecdotal.

Annually through our Transportation Network, we provide thousands of free rides to veterans who need help getting to their Tomah VA medical appointments.

Many veterans feel extreme satisfaction with their Tomah VA health care. Some feel a degree of negativity.

We are all concerned about the allegations of overmedication of veterans in the Tomah VA Mental Health Program and the more recent allegation about possible negligence in the Urgent Care Unit.

Three quick points:

First, all VA investigations of allegations at Tomah and other VA facilities need to be done in a *thorough, forthright and expeditious* manner and reported publicly. Otherwise, if protracted, the allegations in the media begin to define the situations, instead of the investigations' findings.

Secondly, transparency within the VA needs to improve. According to testimony before the Senate VA Committee on February 26th, the original investigation on overmedication of veterans at Tomah VA was delivered to the facility in the spring of 2014 with the directive "not to share."

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VA leadership, including the VA Secretary and the Interim Under Secretary for Health, did not learn of its existence until January 2015. This is troubling.

Thirdly, VA medical investigations, such as overmedication of veterans, need to include a medical peer review. Prescribing for mental health is not a one size fits all treatment. Each case contains variables.

Lastly, I and DAV Wisconsin believe VA should be the primary health care provider for veterans, but improvements are needed.

Questions

1. What current investigations are being done regarding the two allegations?
2. What steps are being taken to improve transparency within VA?
3. Is a medical peer review part of the investigation on overmedication of veterans in the Tomah VA Mental Health Program?

Again, thank you for this opportunity.

Respectfully submitted,



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ADDENDUM: VA Deputy Secretary Gibson made a presentation at the local stakeholders meeting in Tomah which is contained in the enclosures:

1. VA News Release of March 9, 2015: *VA Accelerates Deployment of Nationwide Opioid Therapy Tool*
2. VA News Release of March 10, 2015: *VA Releases Key Findings of Clinical Review of Opioid Practices in Tomah*
3. Department of Veterans Affairs Memorandum of March 10, 2015: *Summary of Phase One Clinical Review Findings, Tomah, WI*

Our concerns and questions were basically answered by the presentation. Overall, DAV Wisconsin feels VA has taken a good *first* step, but to ensure the process is completed in a satisfactory manner, government oversight will be required.

This concludes my statement as amended. I will be glad to answer any questions the Committee may have.

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FOR IMMEDIATE RELEASE
March 9, 2015

VA Accelerates Deployment of Nationwide Opioid Therapy Tool

Allows VA Providers to Review Pain Treatment Data in One Place to Help Protect Patients

Washington – The Department of Veterans Affairs (VA) is accelerating the deployment of a state-of-the-art tool to help protect Veteran patients using high doses of opioids or with medical risk factors that put them at an increased risk of complications from opioid medications.

The tool, referred to as the **Opioid Therapy Risk Report**, is being made available now to all staff in the Veterans Health Administration (VHA). Over the past week, VA's Interim Under Secretary for Health, Dr. Carolyn Clancy, has reached out to over 2,000 primary care providers in VHA clinics throughout the country to promote the use of this novel tool. It includes information about the dosages of narcotics and other sedative medications, significant medical problems that could contribute to an adverse reaction and monitoring data to aid in the review and management of complex patients.

"All of American medicine is aiming to better understand how to treat severe pain, and Veterans receiving care in the VA health care system typically suffer from higher rates of chronic pain than the general public," said Dr. Clancy. "While opioid medications may be appropriate in some cases of chronic pain, we are dedicated to using them safely and providing effective pain care to our Veterans. It is critical that we ensure system-wide implementation of the Opioid Therapy Risk Report in the weeks ahead."

The Opioid Therapy Risk Report allows VA providers to review all pertinent clinical data related to pain treatment in one place, providing a comprehensive Veteran-centered and more efficient level of management not previously available to primary care providers. VHA is actively deploying training aids to providers and facilities now and over the next several weeks to familiarize them with how to utilize this tool in their daily practice.

Oversuse and abuse of prescription opioids is a significant public health issue, particularly since patients in pain are at risk for potential negative outcomes including unintended overdose, adverse medical reactions, and mental health complications. VA established the Opioid Safety Initiative (OSI) in 2012 to enhance safe and effective pain care for Veterans. As a result, there are currently:

- 91,614 fewer patients receiving opioids;
- 29,281 fewer patients receiving opioids and benzodiazepines together;
- 71,255 more patients on opioids that have had a urine drug screen to help guide treatment decisions;
- 67,466 fewer patients on long-term opioid therapy;

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News Release

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FOR IMMEDIATE RELEASE
March 10, 2015

VA Releases Key Findings of Clinical Review of Opioid Practices in Tomah

Clinical and Administrative Reviews Still Ongoing

Washington – The Department of Veterans Affairs (VA) today released key findings and recommendations of its initial clinical review into opioid prescription practices at the Tomah VA Medical Center (VAMC).

Based on these preliminary findings, the team recommended that VA consider a more in-depth evaluation of the clinical and administrative practices at the Tomah VAMC. An administrative review team from VA's Office of Accountability Review (OAR) is continuing to look at allegations of retaliation against employees and other accountability issues related to Tomah VAMC leadership. Investigators from the independent VA Office of Inspector General and the Department of Justice's Drug Enforcement Administration have also been on site.

Yesterday, VA announced the accelerated deployment of a nationwide opioid therapy tool for use at all Veterans Health Administration (VHA) facilities.

The release of the key findings comes as VA's Deputy Secretary Sloan Gibson met today with employees and stakeholders in Tomah.

Go to this highlighted link, [for a summary of Phase One Clinical Review Findings](#).

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**DEPARTMENT OF
VETERANS AFFAIRS****Memorandum**

Date: March 10, 2015

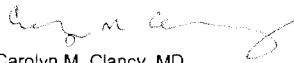
From: Interim Under Secretary for Health

Subj: Summary of Phase One Clinical Review Findings, Tomah, WI

To: Secretary

Thru: Deputy Secretary

1. In January 2015 you directed me to lead a comprehensive review of medication prescription practices at the Tomah VA Medical Center (VAMC) and to report back in 30 days.
2. On January 23, 2015, I convened a clinical review team consisting of nine clinicians and other subject matter experts from across VHA to "assess the practice patterns, controlled substance prescribing habits, and administrative interactions with subordinates and clinical leadership as related to prescribing practices" at the Tomah VAMC.
3. The team submitted a report summarizing its findings on March 4, 2015. Based on a review of computerized medical records of eighteen (18) patients, the team found unsafe clinical practices at the Tomah VAMC in areas such as pain management and psychiatric care. More specifically, six of 18 cases revealed that patient harm (examples of falls) that could be at least partially attributable to prescribing practices (multiple CNS depressants and/or high dose opioids); nine of 18 lacked evidence of changing the treatment plan in the face of aberrant behaviors; and twelve of 18 demonstrated extensive use of opioids and benzodiazepines.
4. The team made specific findings relating to overall opioid utilization at Tomah and other VHA facilities, noting that 11.5% of Tomah patients receive opioid medications as compared to 14.6% of patients VA wide. The team also found that Tomah patients were 2.5 times more likely than the national average to be prescribed opioids greater than 400 morphine equivalents per day (1.08% vs. 0.42%), and were also more likely than the national average to be prescribed opioid doses between 200-300 morphine equivalents per day (1.53% vs. 1.2%). With respect to the use of benzodiazepines and opioids concomitantly, which is discouraged due to risks of complications, the team found that Tomah VAMC was almost double the national average (20.4% vs. 11.7%).
5. The team also found that an apparent culture of fear at the facility compromised patient care and impacted staff satisfaction and morale. Based on these preliminary findings, the team recommended that VHA consider a more in-depth evaluation of the clinical and administrative practices at the Tomah VAMC. That additional review is now ongoing.


Carolyn M. Clancy, MD



March 30, 2015

Tomah, Wisconsin

Joint United States Senate Home Land Security and Governmental Affairs Committee and House Veterans Affairs Committee Hearing: Tomah VAMC: Examining Quality, Access, and a Culture of Over-Reliance on High-Risk Medications.

Dear Chairman Miller, Chairman Johnson, Senator Baldwin, and distinguished members of Congress from Wisconsin and Minnesota:

My name is Daniel Idzikowski. I have the honor of serving as the Executive Director of Disability Rights Wisconsin, the Protection and Advocacy system for people with disabilities, including mental illness in the state of Wisconsin.

Thank you for holding this joint hearing in Tomah, Wisconsin, visiting our local Veteran's Administration facility, and listening first-hand to the accounts of abuse and neglect that have resulted in tragic consequences for Wisconsin's honorable veterans and their families. As you have heard from today's testimony, a lack of proper investigation, monitoring, oversight, and accountability compounded this tragic situation. As Chairman Miller noted, this lack of oversight, monitoring, and accountability is, unfortunately, not limited to the VA facility in Tomah, Wisconsin.

When questions regarding the treatment of veterans in VA facilities first came to the attention of Congress, Representative Ron Kind met with local officials at the Tomah VA facility in his district to learn of any deficiencies. His inquiries were met with an assurance that there were no problems at the local VA. Local officials, under pressure, failed to disclose that any investigation of the facility was underway, or that an Inspector General's report had already been issued. Representative Kind's efforts were thwarted because officials within the Veterans Administration itself conducted the investigation and told local officials not to reveal this report to a member of Congress. As you have heard, the VA Office of Inspector General's report regarding the Tomah VA concluded with no substantiated findings, despite a pattern of deaths from overdose over many years at the facility.

While we cannot bring back the lives lost or correct the harm done, we can move forward to ensure independent investigation, monitoring, oversight, and accountability of Veterans Administration facilities across our nation. You already fund a system that, given the proper authority and resources, can provide veterans, their families, the general public, and members of Congress with an independent voice, investigative access, and vigorous monitoring and advocacy. This system -- which is free of any conflict of interest, government entanglement, or responsibility for service delivery; which already has special access authority and investigative powers granted to it by Congress in all state administered facilities, including state operated veterans facilities; whose mission is to protect and advocate under just these types of circumstances -- is the federally mandated and governor-designated Protection and Advocacy system for people with disabilities.

MADISON	MILWAUKEE	RICE LAKE	
131 W. Wilson St.	6737 West Washington St.	217 West Knapp St.	disabilityrightswi.org
Suite 700	Suite 3230	Rice Lake, WI 54868	
Madison, WI 53703	Milwaukee, WI 53214		
608 267-0214	414 773-4646	715 736-1232	800 928-8778 consumers & family
608 267-0368 FAX	414 773-4647 FAX	715 736-1252 FAX	

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Tomah VA Hearing
Disability Rights Wisconsin Testimony – page 2

Disability Rights Wisconsin already serves as an independent investigator, monitor, and effective advocate for persons treated in state and local mental health facilities. Just this past month, the Milwaukee County Mental Health Complex celebrated the closure of its long-term housing unit for people with developmental disabilities, placing its last resident in an appropriate and supported community placement. Last year, the Wisconsin state legislature vested new oversight authority in an independent Milwaukee County Mental Health Board. A new administrator, focused on improving the quality of care, specifically the quality of medical care received by the thousands of patients served by Complex, was appointed. She has begun the process of reaccrediting the facility. All of these changes came in large part due to persistent advocacy by Disability Rights Wisconsin and, as was the case at the Tomah Veteran's Hospital, after a series of tragic deaths due to medical negligence and mismanagement. Disability Rights Wisconsin's thorough and independent investigation and the report it commissioned in 2012 brought to light the scope of these problems at the Complex and tipped the scales for permanent change.

Often our access, presence, and authority to bring action as the Protection and Advocacy system can prevent such tragedies from occurring. Because we are not embedded in either state or federal government we can exercise this role independently on behalf of the patients and members served. We can access state facilities unannounced and speak with patients, residents, staff and administration unfettered by regulatory constraints. We can sue to prevent abuse and neglect and advocate for change to otherwise incorrigible systems. And we can represent individuals with disabilities, including mental illness who all too often are forgotten and left behind when decisions affecting their lives are made. But today, in 2015, we are locked out of veteran's facilities. We simply do not have the same independent investigative and access authority in federal facilities, such as the Tomah Veteran's hospital, that Congress has granted to us over state facilities. This provides veterans with inadequate and unequal protection under the law. While we can investigate abuse and neglect in a state run veterans home, we cannot do so in a federal Veterans Administration hospital. This simply does not make sense, is not fair to veterans, and must change.

Let me be clear, our national network is ready to work with you to extend the investigative, monitoring, and access authority of the Protection and Advocacy system to federal veterans facilities and to establish and fund an independent Protection and Advocacy program for veterans.

Thank you for your time and opportunity to submit this testimony. I would be pleased to answer any questions you might have regarding this important opportunity to expand protection and advocacy for veterans who have so ably served our country in our nation's armed forces.

Daniel Idzikowski, Executive Director
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Prepared Statement of Linda Simcakoski**"Tomah VAMC: Examining Quality, Access, and a Culture of Overreliance on High-Risk Medications"**

My name is Linda Simcakoski, I'm Jason Simcakoski's mom. This is just a summary of important issues, as I understand them.

Today is March 30th, which is to the day, 7 months that my son died at the VA Tomah facility. Worst day of my life. I can't get out of my mind the day he died, as my husband Marv and I were on our way to Tomah. As we drove we were waiting for a call from the Tomah VA, as to where they were going to transfer Jason, by air. No one called so we called them, just to make sure we were not driving way out of our way. When they informed us to come to the Tomah building, same building Jason was staying in, and to drive slow, we knew he was gone. I felt like jumping out of the car and running, running, and running. I don't know where I was going to run, but I didn't want to go to Tomah. I didn't want to hear the worst thing a parent could hear.

I would like to tell you who my son was. He was an outgoing, positive, determined individual who could put a smile on your face, even on your worst days. He made friends easy, he had many. I always felt that he was going to go far and succeed as a young adult; he had a lot going for him. No matter what he did, he gave it a 100%+, and that was why he joined the Marines. He felt this was the toughest of the military to join and he wanted it.

It was so hard to see him, as he was, in the past few years. Opposite of who and what he was both mentally and physically. He became this individual who was very un-motivated, and withdrawn. His funny, sense of humor part of him changed, he was not "Normal". He always said he just wanted to be normal. He went from this physically fit marine who was always working out, to the individual sitting or sleeping on the couch, overweight. His normal weight was about 180 and he weighed 254 when he died. He wouldn't buy many clothes as he was embarrassed about his size. The only thing he bought was shoes, many shoes, and that was because it was the only thing that stayed the same. This was extremely hard for him; he didn't want anyone to see him like this. He avoided going out in public as much as he could. This was truly not my son Jason.

Jason went to the VA Tomah facility on and off, when he would have issues with his medications. Marv and I always thought the VA was over medding him and express our concerns, but nothing really changed. He did get a new doctor, Dr. Davis, and we met with her, Marv, Jason and I. She told us that she didn't agree on the med's Jason was on, he should only be on a couple of meds. She would be working with him on reducing the meds, which should

also help with his weight issue. We left that day and felt great, that someone finally is listening to us. We really thought this was going to be a big break/change for Jason.

Things were okay at first and then Jason began to struggle, anxiety issues, etc. It seemed that he needed to take pills to wake him up and give him energy for the day, and then he needed to take pills to relax him and help him sleep at night. Jason went back to the VA Tomah facility for help, as he hated feeling like he did. He knew he needed help, he didn't want to feel like this (all medded up), and he wanted HELP. Help to feel like he used to, normal as he called it.

Jason never got the help that he deserved. Jason along with Marv and I, trusted the doctors at the VA Tomah facility as they are supposed to be the professionals, they should know how to treat these veterans. How could you give patient medications that could stop them from breathing? He was there....right at the Tomah facility and he died under their care, not from a heart attack, stroke, or brain aneurism but from meds, meds that they prescribed. How could this happen?????????

Now reading reports and hearing stories of what has been going on for years makes me sick!! How could this happen, how many veterans have died or are messed up on drugs because the people in charge of the VA are too busy doing nothing? How many patients have to die before someone indicates there is evidence of wrong doing?

There's a lot of finger pointing going on with Senators missing reports, etc. doing nothing. It's sad nothing was done, but it's not too late to fix the problem with the VA. Too late for my son Jason, but not the other veterans. If anyone is to blame, it's some of the staff members at the VA Tomah facility that were responsible for my son Jason's death. And don't tell me that no one is responsible, no wrong doings found....that's not acceptable!

It's time that we change things for our Veterans. They should have good quality care, not second hand. If no one steps forward and speaks out for them, then nothing will change. And it will be just a matter of time that this will happen to another family, another veteran.

Comments:

1. The Tomah VA facility indicates they have made changes, changes to redirecting some of the more highly opiate patients to a different doctor, etc. (only high opiates?) What are the guidelines for who qualifies? After finding out how many meds my son was on, he should have been top candidate. Also, who oversees those different doctors, is it not the Chief of Staff?

2. The control of opiates/meds on computer systems is a start, but who will be monitoring this? The problem is not always the system but the people controlling the system. In the Tomah case people complained for years on how bad things were, but people in charge looked the other way. Tomah needs to have new management in order to correct this problem. They decided to do nothing for all these years. They had many chances to fix all of the problems and did nothing, they are responsible. The veterans and all of their families need a good place to go...A CHANGE IS NEEDED NOW, not years from now.
3. I understand there is no simple fix for chronic pain that fits everybody. Not sure why my son was getting pain meds, he didn't have any injuries that he needed pain meds. He indicated he had high anxiety his last few weeks, but never mentioned anything about pain. My son's autopsy had high levels of multiple drugs (not just opiates) in his system. Is the investigation looking into the over-prescribing of all drugs or just opiates?

- 1) The policy needs to change in the Mental Health area that when doctors are adjusting a patient's meds they should have to check on this patient daily while he or she is inpatient.
- 2) There should be a meeting at each VA facility every 6 months (or more if needed) with a group of family members and VA officials to discuss changes that should be made.
- 3) Doctors should not be protected by the VA for Malpractice, they should have the same policy as public hospitals.
- 4) All doctors practicing in a VA facility must have a license for the state they are practicing in.
- 5) Nurses and all other staff members should have input in regards to the patients they are attending to. They should be able to express their concerns regarding a patient to the doctor, working together to correct problems, if any.
- 6) The VA needs to have the same protocol nationwide so they don't have patients cherry picking hospitals that are over medicating there patients.
- 7) Only the doctor in charge of handling the patient should be able to prescribe medications, in their name. Other prescribed medications should only be from another doctor in emergency, or if the primary doctor is not available.
- 8) For patient's that have addition problems, Doctors should not be allowed to send more than a two week supply of addicting Meds to these patients.
- 9) If the VA hospitals can't take care of a patient that needs more care, they should be allowed to go anywhere they need, to get that care.
- 10) VA should not be able to investigate the VA when there are complaints. This should come from an outside source.

Statement of Gail Mackie

Our son joined the WI National Guard at age 17 to protect his country, protect American's freedoms and "be the best he could be". For over 17 years he was a great soldier. Pat was a hard working mechanic with the National Guard and a greatly loved father of 4 girls. He has sought medical care and psychiatric care through the Tomah VA and now every day he faces the loss of his military career, loss of his marriage and kids and the loss of the very freedom he fought for.

Recently the internal investigation of the Tomah VA showed that there were unsafe clinical practices in pain management and psychiatric care and that practitioners took no action to change treatment plans even when patients displayed "aberrant behaviors." Aberrant being defined in the dictionary as "straying from the right course". We wonder if our son is one of these soldiers. Pat went from a good soldier, hardworking mechanic at the National Guard and loving father of 4 girls to a suicidal criminal in about 13 months. All of this occurring while under both inpatient and outpatient care with the Tomah VA psychiatric department. Patrick has had many diagnoses given to him over this period of time beginning with depression and anxiety to alcoholism and then onward to bipolar, post traumatic stress disorder(PTSD) and traumatic brain injury (TBI). He was tried on many medications and combination of medications some of which were beyond the recommended dosages. The side effects of these medications were a lot of what we were seeing in his behavior; mood changes, worsening anxiety, headaches, agitation, irritability, confusion, memory loss, hallucinations, inability to sit still, lack of coordination, dizziness, panic attacks and suicidal thoughts. Although we notified the VA of the things that were happening and how his behavior was changing nothing was done. Although the doctors would tell Pat that alcohol should not be taken with these medications, they knew he was drinking and did nothing to help him. By the way he was acting, something had dramatically changed in Pat's head. We now wonder if his legal troubles and problems with the military arise from the mismanagement of the treatment of his PTSD, overmedication, toxic combinations of medications and lack of practitioners to respond to family complaints of his "aberrant behavior".

Currently our son is at the Tomah VA. He has been there since February of 2014. He has the option of staying at the VA and not leaving the grounds or sitting in jail until upcoming court appearances. He has been through the substance abuse (SA) program and the PTSD program and although we think that he is much better than previous hospitalizations at the VA he has yet to try to live back in society. I had always believed that our son would get the care that he needed from the VA but now I think that the VA has caused his loss of freedom and our loss of years with our son due to their negligence with his psychiatric care and drug mismanagement. If the practitioners at the VA had managed our son correctly we believe that he would never have gotten into trouble with the law and he would still be a National Guard soldier today. It is a sad statement in his life and ours that he fought for our countries freedoms and now due to lapses in his mental health care he may lose his own freedom.

Sincerely,
Gail Mackie

March 30, 2015

JOINT OVERSIGHT FIELD HEARING at TOMAH VA MEDICAL CENTER in TOMAH, WISCONSIN

House Committee on Veterans' Affairs & Senate Committee on Homeland Security and Government Affairs

VA-WIDE HEALTH, SAFETY, AND OVERSIGHT ISSUES HIGHLIGHTED BY OCCURRENCES AT TOMAH VA HOSPITAL

Written statement submitted by Constance A. Walker, Captain, United States Navy (Retired)

As a veteran with over 23 years of active naval service culminating in duty as a Naval Inspector General; as an advocate for Post-911 veterans and family members since 2005; and as a VA-designated primary caregiver for my son, a 100% disabled veteran of our war in Iraq, thank you for the opportunity to submit a written statement and propose Questions for the Record (QFRs) for Congressional leaders' and the Committees' consideration today.

The tragedy of any veteran's death due to mixed prescription drug toxicity, particularly as a psychiatric in-patient in a VA Medical Center, cannot be overstated. Events in Tomah, Wisconsin demand a thorough and timely investigation with meaningful follow-up action to ensure that responsible parties are held accountable and necessary changes are made at the Tomah VA Hospital. Continuing focus by Senator Tammy Baldwin, Representative Ron Kind, the House and Senate Committees on Veterans' Affairs, and the Senate Committee on Homeland Security and Government Affairs will remain key to ensuring that meaningful and appropriate action is taken by VA Central Office, VISN-12, and Tomah VA Hospital leadership to correct conditions leading to last week's hearing in Washington, D.C. and today in Tomah; and to effect positive and lasting changes in clinical and administrative practices at this VA hospital.

At the same time, I urge Congressional leaders and Committee Members here today to consider the following information and proposed QFRs from a viewpoint that extends beyond Tomah to include not only VA hospitals and clinics across the nation, but also non-VA pain management and mental health care providers approved by the VA; either through the Veterans Access, Choice, and Accountability Act of 2014, VA fee-basis authorizations, or VA contracts awarded to non-VA health care entities or agencies.

Veterans, families, and their advocates across the country have rightfully applauded the passage of H.R. 203, the Clay Hunt Suicide Prevention for American Veterans (SAV) Act, and its enactment into law on February 12, 2015. At this time, however, no funding has been authorized to carry out the Act's provisions and future funding is not assured. Meanwhile, a plethora of scholarly reports and articles in the popular press point out the urgent need for improved oversight, monitoring, and coordination of care for veterans treated by VA and non-VA providers who are prescribing opioids for pain management and benzodiazepines (BZDs) for mental health disorders such as depression, anxiety, Post-Traumatic Stress Disorder, Military Sexual Trauma, Substance Use Disorder, and other conditions.

A sampling of the literature includes:

- GAO VA or DOD-VA Health Care reports released in 2012, 2013, and 2014, *"Management and Oversight of Fee Basis Care Need Improvement"* [GAO-13-441]; *"Improvements Needed in Monitoring Antidepressant Use for Major Depressive Disorder and In Increasing Accuracy of Suicide Data"* [GAO-15-55]; and *"Medication Needs During Transitions May Not Be Managed for All Servicemembers"* [GAO-13-26]

- House Committee on Veterans Affairs hearing transcript, "*Between Peril and Promise: Facing the Dangers of VA's Skyrocketing Use of Prescription Painkillers to Treat Veterans*" [GPO Serial No. 113-39, 2013]
- Department of Health and Human Services: "*Benzodiazepines in Combination with Opioid Pain Relievers or Alcohol: Greater Risk of More Serious Emergency Department Visit Outcomes*", SAMHSA Drug Abuse Warning Network (DAWN) Report, December 2014
- "*Risks, Management, and Monitoring of Combination Opioid, Benzodiazepines, and/or Alcohol Use*", released as a NIH Public Access Manuscript from the July 2014 issue of Postgraduate Medicine

There is wide consensus that opioid painkillers and BZDs are highly addictive and potentially lethal when over-prescribed or prescribed in combination without active, consistent monitoring and integrated pain and mental health case management and oversight. With that in mind, proposed QFRs follow.

QFR # 1: What is VA's protocol for monitoring opioid and BZD prescription management for veterans being treated by non-VA providers through the Veterans Access, Choice, and Accountability Act of 2014, and through other non-VA provider arrangements approved by the VA (e.g., individual Fee-Basis Authorizations or VA approved contracts?)

QFR # 2: Recognizing that the Clay Hunt SAV Act is presently an unfunded mandate: In order to ensure timely and comprehensive system-wide evaluation and reporting, will the Government Accountability Office be tasked to conduct a VHA system-wide review of opioid painkiller and BZD prescription policy and procedures, and the consistency of their enforcement (actual practice) at VA hospitals and clinics? If such an evaluation is approved, will GAO also assess the level of collaborative and coordinated pain management and mental health case management oversight for veterans receiving prescriptions of opioids and BZDs from VA providers and VA-authorized non-VA providers?

QFR # 3: Will the VA confer with subject matter experts like those testifying at last week's hearing in Washington, DC; from Kaiser-Permanente, Johns Hopkins Bloomberg School of Public Health, and the Drug Control Division of the Connecticut Department of Consumer Protection; to improve VA policies, procedures, and treatment options for pain management, and to resolve gaps in VA reporting to states to improve prescription monitoring of opioid painkillers and other addictive drugs?

Thank you for your tireless commitment to seeking the best possible health care and treatment outcomes for our veterans and their families, and for the opportunity to offer proposed QFRs in support of the vital issues discussed here today.

Respectfully submitted,

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Post-Hearing Questions for the Record
Submitted to Dr. Noelle Johnson
From Sen. Tammy Baldwin

“Tomah VAMC: Examining Quality, Access, and a Culture of Overreliance on High-Risk Medications”

March 30, 2015

1. Lin Ellinghuysen, the Acting President of the local AFGE union that represents Tomah VA employees, states in her testimony, which will be entered into the record, that, “The most vulnerable employees in this type of destructive workplace culture are those with temporary appointments and recent hires still on probationary status because they have very limited protections against retaliatory terminations, suspensions and other unwarranted personnel actions. Management has targeted these employees with the fewest rights to set an example for other employees with permanent status and send a strong signal as to what will happen to them should they decide to speak up or disagree with care given to veterans.” Ryan and Noelle – both of you were employed at the Tomah VA for under a year. You both experienced retaliation for your whistleblowing. Would you say that your experience is the norm at the Tomah VA? When someone rocked the boat or questioned Dr. Houlihan’s authority at the VA, what usually happened?

I absolutely feel this was the norm at Tomah, specifically in regards to Dr. Houlihan. I was warned by many pharmacists including the previous Chief of Pharmacy Dr. Jim Due, Staff Pharmacist Kaleen Larson RPh, Virginia Schroeder RPh, Dan Hanson RPh, Dave Dettle RPh, and Clinical Pharmacists Dr. Richard Schroeder and Dr. Laureen Savage-Chambers that if I question Chief of Staff Dr. David Houlihan’s MD prescriptions that I would be fired or at least he would make my life very difficult. They gave me many examples of previous employees that were forced to resign or have been fired for questioning one of Dr. Houlihan’s prescriptions. I did witness one of the out-patient providers Dr. Zakia Siddiqi MD be forced to resign for refusing to write a narcotic order for a chronic pain patient who’s urine drug screen did not test positive for oxycodone on more than one occasion. It is well known by many at the Tomah VA, especially among pharmacist that if you value your job Dr. Houlihan was not be questioned. Dr. Houlihan would go as far as giving his personal cell phone number to the Veterans and when you would question the prescription the patient would call him in front of you so he could yell at you to fill the prescription and quit questioning him. He blamed another pharmacist for the suicide of a patient that she was helping treat as she requested he obtain a urine drug screen prior to the next opioid renewal. When the patient found out he needed to provide the sample and he could not pick up his medication until that was done he committed suicide that night. Dr. Houlihan encouraged the family to file a Federal Tort Claim against the pharmacist and then proceeded to continue to harass the pharmacist for questing the situation and requesting the urine drug screen be obtained. The Federal Tort claim was dismissed, however the pharmacist felt forced to resign to escape the continued mental and verbal torture she was receiving from Dr. Houlihan.

Below is a statement from my Office of Special Council compliant. Outlined are some of the instances that happened to me and the repercussions for questioning Dr. Houlihan.

Friday 11/21/08 I was the “hot seat” pharmacist. This pharmacist fills the window prescriptions for the patients that are waiting at the pharmacy. I received a prescription for Morphine Sulfate IR (i.e. immediate release) 15mg 7 tabs every 4 hours, 2 tablets three times daily prn (i.e. as needed) #1080 for a 30 day supply written by Dr. Houlihan. I quickly reviewed the patient profile in his medical record CPRS (i.e. computerized patient record system) to get a better assessment of what the indication for the short acting narcotic pain medication was for and to assess the type of pain being treated as well as other medications the patient had previously failed. This patient had somatic pain from a previous healed fracture of the T12, in addition to neuropathic pain with radiculopathy. After this brief assessment of the patient my initial clinical judgment was to question the short acting agent of choice and the quantity that was prescribed. After having experience working as a clinical pharmacist in a pain clinic at the VA in Columbus OH, I clinically felt this patient’s pain was not being properly treated. Strictly treating a patient with only short acting medication is not the standard of care. I felt this patient would benefit from a long acting narcotic, a NSAID (i.e. non-steroidal anti-inflammatory drug), and a medication to appropriately treat his neuropathic (i.e. nerve pain) pain. I felt the short acting immediate release morphine was inappropriate monotherapy. The prescription was due to be filled on 11/24/08. The prescription was early, so I felt I had time to look into the patient’s medical records to better formulate a recommendation for the provider.

I asked many of my colleagues including Clinical Pharmacists Dr. Laureen Savage-Chambers, Dr. Richard Schroeder, Dr. Margaret Hyde, and Dr. Erin Narus, and they felt the prescription was inappropriate as well. I was told not to question the order because it was from Dr. Houlihan and he doesn’t like pharmacists questioning his orders. I was told by multiple clinical and staff pharmacists if I question the order and try to make recommendations he did not agree with, then he would try to fire me or at least make work unpleasant for me. I discussed the prescription with multiple pharmacists and I asked how the prescription had been getting filled thus far. The responses I received were statements such as, “I’m sick of fighting with Dr. Houlihan,” or “I’m not calling Dr. Houlihan, I don’t want to have to fight with him about anything today...good luck with that...I’m glad I’m not you.” or “Last time I called and questioned an order, Dr. Houlihan called the previous Chief of Pharmacy Dr. Jim Due and told him I was trying to cause a problem.”

I took the prescription to the new Chief of Pharmacy Dr. Erin Narus to review the prescription. She agreed the patient needed to be on a long acting narcotic medication as well as possibly an NSAID and a medication to treat the neuropathic pain. While I was in Dr. Naurs’s office I received a call from Dr. Locker MD who wanted to know if a pill identification had been done as he believed this particular patient had brought his own immediate release morphine sulfate from home and was taking this in addition to the immediate release morphine we were giving him while he was admitted to the VAMC. This would have been a direct violation of the patient’s pain contract. Dr. Locker wanted to let Dr. Houlihan be aware of this violation before Dr. Houlihan wrote a new prescription for immediate release morphine upon discharge 11/21/08. The medication should have been taken away from the patient and locked up in inpatient pharmacy as this is standard protocol. This however did not happen. Dr. Locker spoke with Dr.

Houlihan about his concerns with the patient and his over use of this short acting pain medication. I spoke with Dr. Locker and Berry Emerk PA-C about the pill identification. While on inpatient unit 400 observation, I showed the two providers the prescription. Both providers said, "We are glad our name isn't on the prescription." This in addition, added to my concerns about the appropriateness and safety of the prescription. The patient has built a large tolerance to this medication, which happens very quickly with short acting analgesics, and is now taking more than prescribed. This patient will likely continue to require more and more medication as he builds tolerance and dependence. Is this a case of pseudo addiction because the patient's pain is not properly treated? Due to the fact the patient had been an inpatient for a few days and was receiving immediate release morphine in the hospital and was requesting the prescription early the patient should have had enough medication to cover through the weekend and therefore was not going to be without any medication.

My plan which was discussed and agreed upon with Dr. Narus was to go through the patients' medical record more in depth and devise a plan to help convert the patient over to a long acting narcotic medication and start to taper the short acting immediate release morphine. I consulted with the Board Certified Pain Specialist, Dr. Sanhaj and Clinical Pain Pharmacist, Dr. Staci Jackson that I previously worked with in my residency to reinforce the decision to request this patient be converted to a long acting narcotic and how to safely go about converting someone on such a large unsafe dose.

I did not have time to thoroughly go through the patients chart until Monday morning 11/24/08. All weekend long I dreaded having to make this phone call. I was afraid to call Dr. Houlihan to discuss this case after everything my colleagues had told me. I even lost sleep over it. I woke up multiple times and went over my game plan how I could tactfully and professionally approach this situation and make a recommendation to Dr. Houlihan to help him treat this patient without upsetting him, but that would safely and effectively treat the Veteran. First thing Monday morning I met with Dr. Narus and reviewed my plan with her. I asked her how to approach Dr. Houlihan knowing it was going to be a tough situation. She gave me some advice on how I could broach the subject. I had to give myself a pep talk just to pick up the phone. I have never been afraid to contact a provider to question an order or provide a recommendation before because that is my job and I know it is in the best interest of the patient. I called Dr. Houlihan's nurse Susan Schmitt and she told me he was with a patient. I told her I had a question in regards to an order, but it was an in depth question so he could call me back at his earliest convenience. The nurse ended up transferring me to Dr. Houlihan. I told Dr. Houlihan that my name was Noelle I was one of the pharmacists and I had a question in regards to the immediate release morphine order for this particular patient. I asked if Dr. Locker had spoken with him in regards to this patient taking his own morphine while admitted to the VA as an inpatient. Dr. Houlihan said he spoke with Dr. Locker. Dr. Houlihan said, "This patient did not take his own morphine while he was here." I told him I had looked through the patient's medical record and saw that he had somatic pain as well as neuropathic pain with radiculopathy. The patient had been on long acting morphine in the past. Dr. Houlihan said, "He wasn't tolerating the medication." I said, I read in the chart he was taking more than prescribed, not that he wasn't tolerating the medication." I then said I think this patient would benefit from a long acting pain medication would you consider starting him on another long acting narcotic medication. I was thinking methadone. It is a good medication for patients with somatic and neuropathic pain. This

is where Dr. Houlihan began to get upset. He started to get very stern and short with his answers and he starting raising his voice. He said, "The patient has addictive properties so methadone would cross the lines to addictive treatment which would need a special license." (Methadone for addiction requires a special license. Methadone for chronic pain management does not). Dr. Houlihan then asked me, "What is the bottom line, what are you really trying to say?" I said, "I clinically don't feel comfortable filling this prescription. I really feel the patient needs a long acting medication. Where are you going to go with this patient's medication regimen? The patient is going to just keep building up tolerance and greater dependence. Are you just going to keep increasing the dose?" Dr. Houlihan responded by yelling, "I'm sick of you pharmacist questioning my prescriptions. By questioning my prescription you are questioning my clinical judgment and my authority, thus by doing so are putting my license in jeopardy!" I said, "I am not trying to question your clinical judgment; I am trying to help the patient and you come up with the best way to safely and adequately treat this patient's pain." Dr. Houlihan said "Yes you are, you are questing my clinical judgment and how I treat my patients. Someone has to see these patients and it is me." I said, "I was told you are the only one who sees the chronic pain patients." Dr. Houlihan said, "Yes, I am the only one who can. If you don't want to fill this prescription and you want to question me all the time than you can be the one to find these patients a new Dr. to see them. How are you going to do that? No one else is going to see them! Are you going to see them?" I said, "I would like to work with you to help find the right pain regimen to treat this patient." Dr. Houlihan responded by telling me what needed to be done was, the prescription needed to be filled. I replied by telling him, "I do not feel comfortable filling the prescription and I will not do so. I would find you another pharmacist to fill the prescription, but my name will not be on the prescription because it is not in the best interest of the patient." Dr. Houlihan said he would be speaking to Dr. Narus about this situation. I told Dr. Houlihan that was fine Dr. Narus was aware of the situation. Dr. Houlihan hung up the phone.

I instantly starting crying after hanging up the phone. I felt very attacked. I as well as the other pharmacists do not deserve to be treated like that. I as well as my colleagues deserve to be treated with respect, dignity, and civility. I believe Dr. Houlihan behaved in an unprofessional and threatening manner. I now know what the other pharmacists were talking about and why everyone is afraid to recommend any changes to Dr. Houlihan. I don't feel I should have to be afraid. I feel that I did what was right. I stood up for patient safety, my ethics, and protected my license. Filling that prescription was not clinically in the best interest of the patient. I feel I had every right to question the prescription and not fill it based on my clinical judgment. The technician Mrs. Toni Johnson was standing next to me filling narcotic prescriptions during my phone conversation with Dr. Houlihan. Mrs. Johnson wrote a statement to attest to my professionalism.

I tried to give the prescription to another pharmacist so they may have the opportunity to fill the prescription if they chose to do so based on their own clinical judgment. The other staff pharmacists refused to fill the prescription as well once I had questioned the order. The prescription was filled by Dr. Narus. After the phone call I went to the clinical pharmacy office for support from my fellow colleagues. They also agreed the prescription was inappropriate and that Dr. Houlihan acted in an unprofessional manner. I then filed a grievance with the union in regards to this matter. The Inspector General was contacted in regards to a different matter. Shortly after this incident Labor and Management had a meeting. In this meeting Dr. Houlihan

stated, "A pharmacist turned me into the Inspector General." I never at any point in time contacted the Inspector General.

I was nominated by Performance Improvement Leader Tracey Lane to be the chair of the Tomah VAMC pain committee due to my background working in a pharmacist run pain clinic in conjunction with a board certified pain specialist while in my residency at Chalmers P. Wylie VA Ambulatory Care Clinic in Columbus, OH. The interim Chief of Pharmacy at that time was Dr. Erin Narus who decided the pharmacy was too short staffed for me to spend the time necessary to be the chair of the pain committee; however, she decided I would be the pharmacy representative for the committee. After questioning the first prescription I was kicked off the committee by Dr. Houlihan. He told the Union Steward, Diane Streeter that I acted unprofessional in regards to this specific patient matter. Diane stated, "She was not unprofessional and she has a witness who wrote a statement stating she maintained her professionalism." At this time Ms. Streeter stated she had tried to bring up the issue of starting a pain clinic and using me as an integral provider in the clinic. Per Ms. Streeter, Dr. Houlihan stated there will never be a pain clinic in this facility and if pharmacy takes over pain management then patients will start dying. If this happens patients will bring their guns to pharmacy and start shooting. After this incident I was told by Dr. Narus and Service Line Manager, Jeff Evanson that I was no longer to call Dr. Houlihan. I was instructed to fax him my recommendations because he is unable to control his temper and faxing was Dr. Houlihan's preferred method of contact.

On 12/12/08 I received a prescription for a Controlled Schedule II narcotic printed on a white piece of paper from Dr. Houlihan. This prescription was a work order copy. Any employee that had computer access could have printed this prescription off CPRS. At this time the Tomah VA required all CII prescriptions to be hand written by the provider on the green prescription pad assigned to each individual provider. Some VA's were transitioning to using the computerized form of a CII prescription. This prescription was printed as a work order, not a computerized CII prescription. As far as I and the other pharmacists were aware we were still requiring the green prescription copy. I tried paging Dr. Narus multiple times and did not get a response. The patient was waiting for the prescription to be filled and was irritated it was taking so long. I decided to go to Dr. Houlihan's office to ask his secretary to have Dr. Houlihan rewrite the CII on the green copy. Dr. Houlihan's office door was open and he heard me talking to his secretary. Dr. Houlihan came running out of his office yelling at me. He said, "This is a legitimate prescription and I will not rewrite the prescription. He yelled I am so sick of you fucking pharmacist! I want to speak to Erin Narus immediately!" He marched down to out-patient pharmacy and I paged Dr. Narus again to come to the pharmacy. Dr. Narus and Jeff Evanson came to the pharmacy and had a meeting with Dr. Houlihan in the back. I went back to filling prescriptions and I could hear Dr. Houlihan maligning me. I was never brought into the discussion to defend myself. As it turned out Dr. Narus and Dr. Houlihan had made a prior agreement that Dr. Houlihan would start to write the CII prescription on the computerized from due to a previous confrontation he had a week prior with another pharmacist in regards to misspelling a patients name 3 times. This change was not communicated with any of the pharmacists. The prescription still had to be rewritten as requested due to the fact it was a work order, not a prescription written and printed correctly from CPRS. On 12/15/08 Dr. Narus handed out a new hard copy guideline exclusively for Dr. Houlihan

February 2009: New Chief of Pharmacy Dr. Tom Jaeger and Dr. Savage-Chambers attend a Medical Executive Meeting. In this meeting Dr. Houlihan again told everyone that I turned him into the Inspector General. Both parties told Dr. Houlihan that I did not turn him into the Inspector General.

February 6th I had a meeting with Dr. Jaeger and Union Steward Diane Streeter. This meeting was to discuss the verbal threat Dr. Houlihan made in the Labor and Management meeting. In this meeting Dr. Jaeger gave me suggestions of agencies to contact with my concerns. He gave me the paper work for the Inspector General and JACHO. Dr. Jaeger explained, he thought JACHO was the best avenue to pursue for reporting the unsafe practices of Dr. Houlihan.

At this point Dr. Jaeger assigned me to the VISN 12 (regional level) Pain Committee. I was also assigned as the leader of the Opioid Work Group by Tracey Lane from performance improvement which I was later removed from.

On March 9th, 2009 I received a prescription from Dr. Houlihan for Methylphenidate Sustained Release 120mg/day. The max dose of this narcotic stimulant medication is 60mg daily. I reviewed the patient's medical record and discovered the patient had previously been on this dose. I also noted the patient had a strong cardiac history. I did not feel this was a safe dose for the patient. This medication is a lipid soluble medication. If given too high of a dose the medication could over saturate the enzymes used to break the medication down and therefore build up in the patient's system and potentially cause harm such as a cardiac arrhythmia due to the stimulant properties. I faxed Dr. Houlihan and asked if the dose could be reduced or if the medication was not beneficial at a lower dose if he could choose an alternative agent for the patient. Within a couple of days Dr. Houlihan wrote a new order for the same dosage and commented on the prescription, "Pt is a large man, fill as is." This medication is not weight based for adults. Dr. Savage-Chambers and I resourced with colleagues at the VA in Madison to see if any doses greater than 60mg have ever been filled. One prescription had been filled for 70mg, other than that dose above 60mg had not been filled. I consulted with many of the clinical and staff pharmacists and they all felt the medication dose was unsafe. I gave the prescription to my previous Interim Chief of Pharmacy, now Out-Patient Supervisor Dr. Narus who also agreed the medication dose was unsafe. Dr. Narus was going to talk to Dr. Houlihan. A few days had gone by and nothing had been done with the prescription. Dr. Narus was called away from work for personal reasons. I received a call in clinic from one of the out-patient staff pharmacist Kaleen Larson, RPh. She stated, "The patient is coming to pick up his Methylphenidate and Erin would like the prescription to be partially filled until further clarification from Dr. Houlihan. I want nothing to do with this prescription you need to come over to out-patient and fill this prescription." Dr. Narus had written directions on the prescription to give a 7 day supply. There was also a yellow note stuck to the prescription that stated I was to tell the patient to only take 2 tablets twice daily until further clarification from Dr. Houlihan. There were two separate problems at hand. It is illegal to partially fill a CII narcotic prescription unless you do not have sufficient quantity to dispense the total and then you only have 72 hours to dispense the remaining or the rest of the prescription is null and void. It is also illegal and unsafe to tell the patient to take different directions than what is written on the bottle or what the provider has prescribed. I was not going to illegally partially fill a prescription and I was not going to tell the patient to take different directions than what the Dr. had prescribed. Dr. Jaeger was out of the

office and now so was Dr. Narus. I brought the prescription to my Service Line Manager, Mr. Jeff Evanson who is not a pharmacist or licensed professional. Mr. Evanson's response was, "Why are you trying to cause trouble?" I explained that I wasn't trying to cause trouble, that this was an unsafe dose for the patient and I was not going to illegally fill the prescription as I had been asked to do. He stated, "Why are you trying to throw Erin under the bus?" I again explained that was not my intention, but the patient was coming to get the prescription at the pharmacy and neither Dr. Narus nor Dr. Jaeger were available. I was not going to fill the prescription at the unsafe dose. I was unwilling to fill it illegally and the other pharmacists were not going to fill the prescription either. Mr. Evanson responded by saying, "If Dr. Houlihan said to fill the prescription you will fill it. You have no right not to!" I responded by saying, "I am an individually licensed pharmacist. I am 50% liable for anything that happens to that patient. I in good conscience cannot fill that prescription just because a provider thinks that I should. It is my job to make sure that prescription is safe for the patient to take. If something were to happen to this patient I am liable and I am not willing to compromise patient safety and my ethics. Mr. Evanson and I continued to debate the issue for over an hour. Mr. Evanson stated, "How dare you claim to be an expert! He asked, why have the other pharmacist filled the medication so far?" I explained that the other pharmacists told me they were told not to question Dr. Houlihan's prescriptions and they were afraid they would be fired if they made a recommendation he did not agree with. I then told Mr. Evanson that Dr. Houlihan could fire me, but I was going to stand up and do what was right and safe for the patient. I was not, and will never be willing to compromise patient safety and my ethics. Mr. Evanson responded by saying, "Houlihan doesn't have the authority to fire you, only I can make that decision." The conversation ended by Mr. Evanson asking to speak with my Clinical Coordinator Dr. Schroeder. Dr. Schroeder, Dr. Savage-Chambers and Union Steward Peggy Burke attend a meeting with Mr. Evanson. Both clinical pharmacist supported and clinically agreed with my decision. Dr. Savage-Chambers wrote the error up in our good catch log. This is a log of provider errors that are kept track of. The patient did not receive the medication that day. When Dr. Narus returned she spoke with Dr. Houlihan and the order was changed to 60mg total daily dose.

After this incident Dr. Jaeger asked me to write a standard operating procedure (SOP). He wanted me to write a procedure that stated if the provider disagreed with the clinical recommendation that we had to fill the prescription as is. If the pharmacist documented they clarified the prescription then the liability was no longer placed on the pharmacist. I disagreed with this and did not feel comfortable making the SOP without legal advice. I called the Iowa Board of Pharmacy. They advised me that the pharmacist is still liable for those prescriptions even if there is documentation of clarification. They advised me to not fill anything that was unsafe for the patient. They also recommended I contact Inspector General as it seemed we had a problem in the Tomah VAMC. I gave Dr. Jaeger this information and wrote the SOP accordingly.

March 30th, 2009 Janice Waldstein a NP from the Wausau Community Based Out-Patient Clinic emailed Dr. Jaeger to compliment my professional abilities and report our positive interactions over the previous 5 months she had worked in the CBOC. Dr. Jaeger responded by saying, "Thank you for the feedback. I agree that Noelle is an exceptional pharmacist. It is always nice to get this sort of feedback to assure her that her work is appreciated. Thanks."

May 12th, 2009 I attended the Tomah VAMC pain committee meeting. While in this meeting the new chair of the committee Dr. Whiteway MD told us that some key stakeholders would be having a meeting in regards to a proposal for starting a pain clinic. He named some of the key stakeholders which included himself, Deb Frasher co-chair, Dr. Houlihan, Associate Chief of Staff, Dr. Picca MD and then he said, "And your colleague Dr. Margaret Hyde. I don't know her. Why would she be asked to attend?" I didn't explain the situation at the current time as there were many people around and it was not the appropriate time or the place. After the meeting I explained to Dr. Whiteway that Dr. Houlihan and I didn't exactly see eye to eye. I gave him some of the examples of the prescriptions I felt were unsafe for the patient and consequently refused to fill, as well as some other examples of questionable practices. I also explained that another clinical pharmacist Dr. Margaret Hyde had been consulting with Dr. Houlihan on some of his pain patients. Dr. Whiteway told me he received an email that said I was not to attend the meeting and that he was to find another pharmacist. At this time Dr. Houlihan named Dr. Hyde. At this time I told Dr. Whiteway and Deb Frasher NP that if Dr. Houlihan is unwilling to work with me that it might be in the best interest of the patients and the committee if I step down. They agreed and Deb Frasher told me that I could work from behind the scene to help the patients and Dr. Hyde. Approximately seven months prior Dr. Hyde approached me in front of Dr. Savage-Chambers and asked me to teach and guide her in relation to managing diabetic and chronic pain patients.

May 15th, 2009 I then set up a meeting with Dr. Jaeger and Dr. Hyde. At this time we all agreed for consistency purposes it needed to be the same person on all committees and clinics. I told Dr. Jaeger and Dr. Hyde that if the support wasn't there from the Chief of Staff to be on the pain committee and in the pain clinic, then I didn't feel I should be following the individual pain patients that I had been making recommendations on. They both agreed and Dr. Jaeger assigned Dr. Hyde to all the committees in my place. I then gave Dr. Hyde a list of the few patients I was still following for specific providers. She agreed to take over the monitoring of these patients. Most of these patients were now stable so they could have been sent back to primary care.

May 27th, 2009 I received a prescription from Dr. Houlihan for a prescription that was written for 1,447mg of Morphine equivalent. This was a 100% increase in dose for this patient. I knew this patient was a difficult patient and that Dr. Hyde was working on this patient with Dr. Houlihan. I reviewed the medical record with Dr. Savage-Chambers and there was no documentation at the time as to why Dr. Houlihan was increasing the dose 100% or that the plan was to admit the patient for observation on June 1st. Dr. Hyde did not have a pager at the time and was in an infectious disease meeting. The patient again was waiting so I called Dr. Hyde in her meeting. I asked Dr. Hyde why they were doing 100% increase. I said, "In most cases a 100% increase at such a high dose is contraindicated. Why would Dr. Houlihan do a 100% increase if a 25% increase would have been beneficial. Dr. Hyde then raised her voice at me and said, "You don't know what you are talking about, I have been in practice a lot longer than you. Just because you worked in a pain clinic doesn't mean you have seen everything. The patient increased the dose 100% on his own!" The prescription was then filled. Five minutes later I saw Dr. Hyde in the hallway. She stated, "They are going to admit that patient for observation on Monday." I then asked her why we gave him a 30 day supply of a narcotic medication at that dangerous dose if he was going to be admitted as an inpatient in 4 days, especially if he was self-escalating his dose. I also told her after looking back at his refill history that even at the 100%

increase he should still have enough medication to last until Monday. Dr. Hyde then walked away. The patient was not admitted on Monday June 1st.

Beginning of June I was contacted by Drug Enforcement Administration; DEA investigator Thomas Hill and asked to comply with his investigation regarding Dr. Houlihan. I agreed to meet with Mr. Hill (414-839-5682) and did so on June 6th, 2009. I met with Mr. Hill and my parents at my apartment in Tomah for about 2 hours. I gave Mr. Hill examples of about 10 of Dr. Houlihan's patients and the unsafe narcotic prescriptions he was prescribing. The examples included the unsafe doses, duration, and quantities of these narcotics which are listed in this report, in addition to examples I was not specifically involved with. We also discussed the 3 unexplained deaths at the VA over the last couple of months. All of which were Dr. Houlihan's patients. I gave Mr. Hill the names of another pharmacist and private physician who wished to help in Mr. Hill's investigation. Mr. Hill informed me the Attorney General would likely be speaking with me. He said he would be asking for an immediate suspension of Dr. Houlihan's DEA License. I was advised not to fill anything I did not feel was safe for the patient or anything that was outside of the normal scope. Mr. Hill informed me he would be in contact.

June 8th, 2009 I received a prescription from Dr. Houlihan for the narcotic Dextromethamphetamine Sustained Release 30mg three times daily. This is usually a once daily medication. It could at times be a twice daily medication if it wasn't lasting long enough, however it should not be used three times a day. The short acting medication is used three times daily instead. Like the Methylphenidate prescription the max dose was 60mg/day. It has very similar pharmacokinetic properties. I again felt uncomfortable with the dosage and the duration. I initially filled the prescription because I was so sick of fighting. By the time the prescription got to the front of pharmacy I felt so guilty and afraid it may harm the patient. I took the prescription back and discontinued the computer order because my name was on the prescription. I kept the hard copy intact. I brought the prescription to the attention of Dr. Savage-Chambers for advice. She agreed the prescription was not appropriate. At this time I went back to the pharmacy to speak with the patient. The patient said he was taking the medication because he could not focus. This patient had a diagnosis of schizophrenia and that was the indication listed in his medical record. This medication is cautioned in such patients especially at high doses. It can cause hallucinations and mania and the studied dose was listed as 10mg daily per multiple drug references. The patient presented with both of these symptoms. The patient had enough medication to last until the 11th so I told the patient I did not feel comfortable dispensing this medication and there was a question in regards to the safety of his dose. I wanted to look into more research before making a decision. The patient was in agreement with this plan, however his wife got very upset and called Dr. Houlihan's nurse Susan Schmitt. In the meantime, Dr. Savage-Chambers had sent an email to Dr. Jaeger asking if the medication could be reviewed by Dr. Picca who is the head of Pharmacy and Therapeutics Committee as Dr. Houlihan was out of the office. In the meantime Dr. Houlihan's nurse called me and told me I was to fill that prescription and that Dr. Houlihan was not available for consultation. I told her I was aware, and the prescription was going to be reviewed by Dr. Picca. She said, "Dr. Houlihan would not be happy about this and you should just fill the medication as the patient has been on this dose before." I explained to her again, I was not going to fill the medication until I could look into the toxicology further to make sure it was safe for the patient.

I asked Dr. Narus if she would fill the prescription, she declined. She agreed it should go to Dr. Picca for review. The next day I started looking into the toxicology information and more in depth in the patient's medical record. I observed a note scanned into this patient's chart from an outside physician. This physician claimed to be following this patient for his chronic pain. The outside physician was prescribing long acting narcotic OxyContin **twice** daily for the patient. The patient had a recent drug test and he tested positive for methadone, another long acting pain medication. This patient claimed that he was on methadone a long time ago. The patient never received methadone from any VA. The medication is very long acting, however it should not show up in a urine drug test after about 3-9 days after discontinuation depending on length of therapy and varying references. The patient also claimed he was taking his amphetamine "prn" The provider asked the patient to come back and do another drug test. The patient did not have one done, so the outside provider was discontinuing his OxyContin. Dr. Houlihan wrote OxyContin for this patient **three** times daily. I started to look at the refill dates listed in the letter scanned from the outside provider and the dates the patient was getting OxyContin from the VA. The refill dates were only a week or two apart for a 30 day supply. The patient was again in violation of his pain contract and this allowed me to believe the patient was diverting the narcotics and taking other narcotic prescriptions illegally. In addition, this same patient left his cell phone in pharmacy by accident. The Staff Pharmacist, Dave Dettle, RPh picked up the phone and on the other end a man was trying to buy medication from this patient's phone.

I printed this information and highlighted it and gave it to Dr. Jaeger who decided to still fill the prescription as is per Dr. Picca's request on June 12th. When I gave the information to Dr. Jaeger, he just looked at me and said, "Whatever!"

June 16th, 2009 at 4:10pm Dr. Jaeger took me in his office and said, "You are going to be fired as of 4:30pm today. They were going to fire you on Friday June 19th, but for some reason they are going to fire you today instead." He proceeded to tell me he thought that I was a wonderful pharmacist and I was just too progressive for this place. I was going to make a great clinical pharmacist for some other facility. He stated, "I will write you a letter of recommendation and I will stand up for you. I will defend you." He proceeded to give me his cell phone number and his personal email. Dr. Jaeger then told me, "If you let them fire you than you will be deemed unfit for federal employment and I don't want to see that happen so I hope you will resign. You have to make a decision by 4:30pm today." I asked, "Why am I being fired." Dr. Jaeger told me there were some reports of contact. I asked, "From whom?" He stated, "I was one of them. I didn't mean it, and I tried to take it back, but it was too late. I wanted to take the report of contact back, but it was taken off of the Interim Service Line Manager Susan Robinson's desk." He then proceeded to explain that neither Susan Robinson nor he knew that I was going to be fired. Dr. Jaeger stated, "I thought there was going to be a performance improvement plan made." Dr. Jaeger then stated, "Please don't let them fire you." Dr. Jaeger then asked if I wanted him to write my letter of resignation. I agreed, and he wrote my letter of resignation on his computer. He replaced his information on a pre-written letter of resignation with my information, he then stated, "I'm resigning as of June 26th. I am not going to put up with this. What happened to you was wrong. I don't want to work for an organization like this. I am done with the Federal Government forever." I then went to Susan Robinson's office to hand in my resignation and she told me I needed to go to Dave Dechant's office in human resources.

I proceeded to Dave Dechant's office accompanied by Union Stewards Diane Streeter and Peggy Burke. I gave Dave Dechant my resignation form. Dave then said, "You do not have to make this decision to resign or be terminated until June 30th" I then took my resignation form back. He proceeded to give me a memo of separation. I asked Dave for an explanation of why I was being terminated. He stated, I was in my probationary period and based on "performance issues" I was not going to become a permanent employee. Dave gave me copies of two reports of contact. One was from Dr. Margaret Hyde and the other was from Dr. Tom Jaeger. I asked Dave how this could be done. I was never given a verbal or written warning on anything and both of my performance evaluations were fully successful. The reports of contact were not verified and were not truthful. Dave responded by saying, "It doesn't matter they didn't have to warn you because you are still in your probationary period." I later discovered my probationary period end date was July 6th 2009. At that point in time I was to return to work the next day. Peggy Burke and Diane Streeter asked for me to be given one day of authorized absence to pull myself together before returning to work. I then proceeded to the union office where I received a call from Dave Dechant. I was then granted authorized absence until June 30th and I had to hand in my keys and badge. At this point all of my computer access was terminated. Later that evening I had a 2 hour phone conversation with Dr. Jaeger. Dr. Jaeger told Dr. Ashmus, my mother MAJ Johnson, and I that he felt coerced into writing the report of contact and if he could, he would take it back. He agreed to write a retraction statement.

June 17th MAJ Johnson, Dr. Jaeger, Union Steward Diane Streeter and I had a meeting. Dr. Jaeger again stated he did not know who fired me. He stated, "Neither Susan Robinson or I fired you." He also stated again, "I felt coerced into writing the report of contact and if I could, I would take it back." He said, "I will be glad to write a retraction statement." Dr. Jaeger also stated at this meeting Dr. Houlihan still thinks I turned him into the Inspector General. At this time Dr. Jaeger also reported, "I think Dr. Houlihan acts like he is on a cocaine high."

June 17th I had a meeting with Human Resource Coordinator Dave Dechant, MAJ Johnson, and Union Steward Diane Streeter. Dave Dechant told us that I turned Dr. Houlihan into the Inspector General. I again told him I never turned Dr. Houlihan into IG. Dave Dechant said, "You were fired based on a committee decision compiled of upper management." He would not say who made up this committee or divulge who made the actual decision for termination. He did report it was not Susan Robinson who brought him the reports of contact. I also asked for the VHA directive that states a probationary employee can be fired without any verbal or written warning. Mr. Dechant was unable to provide such a VHA directive for probationary employees. Mr. Dechant stated he contacted Milwaukee Human Resource department who was also unable to provide such documentation or any directive related to termination of a probationary employee.

June 17th, Dr. Houlihan called a meeting with the two least senior pharmacists. This included Dr. Heather Ashmus and Out-Patient Staff Pharmacist Rebecca Bell. In this meeting he professionally slandered me by discussing the terms and conditions of my termination as well as the differences we incurred. He advised that if they value their job, they would not question him like I did. He fabricated information by telling them I threw papers in his face and that he was a Board Certified Pain Specialist. He told them he was not the one who "pulled the trigger" on me. These were interesting choices for words considering Dr. Houlihan threatened about patients

shooting the pharmacist who took over pain management while in a labor management meeting with Union Steward Diane Streeter.

June 18th Dr. Jaeger resigned from the Tomah VA. Per Dr. Ashmus, Dr. Jaeger stated I'm done with this place, I'm not ever coming back. I will not stand around and take the fall for Noelle's termination.

June 23rd I had a meeting with Associate Director Sandra Gregor, Human Resource Coordinator Dave Dechant, and Union Steward Kurt Hass. Sandra Gregor reported I was fired based on the reports of contact and the recommendation from Chief of Pharmacy Dr. Tom Jaeger. Dave then gave me a copy of a new report of contact that Dr. Jaeger had written. This stated he would not retract his previous report of contact. He stood by his decision that my performance was considered unsatisfactory due to refusing to fill multiple prescriptions.

I told Sandra Gregor I would like to write a report of contact on the professional slander Dr. Houlihan had made. She responded by saying, "That is your word against his and the other pharmacist." I said exactly! I was fired for reports of contact that were falsified and never verified. I was never given verbal or written warning, or the chance to defend my position. She then stated, "I stand by the decision for termination." Immediately after my termination and Dr. Jaeger's departure the pharmacist who wrote one of the reports of contact Dr. Hyde was appointed to the position of Acting Chief of Pharmacy.

Not only is reprisal the norm at Tomah VA in regards to Dr. Houlihan, many of the mid level and executive level management continued to condone and join in the retaliation with Dr. Houlihan. They compromised their ethics to do as he said and maintain employment. Once this has occurred the lies and reprisal continued at all levels to cover the mistakes and errors made by those in administration. The management practices at the Tomah VA are unacceptable. Despite all who knew about the dangerous practices both clinical and administrative at the Tomah VA, no one has been willing to hold any of those employee's accountable. The facility has created an atmosphere of intimidation and fear of reprisal in which they have made examples out of several employees. This has led to further retaliation, reprisal, fear, and continued patient harm. The Inspector General's report did substantiate that pharmacist uniformly were fearful to question Dr. Houlihan or any of his prescriptions due to fear of reprisal. This toxic culture of fear is the worst possible scenario. If the medication expert who dispenses the medication and is supposed to be the last safety check is too afraid to do what is right and safe for fear of reprisal, that is when patient safety is compromised. This was demonstrated by several examples of patient harm and overdose. The treatment provided to Jason Simcakoski is a prime example of this at all levels. If providers, pharmacy, and nursing would not have been fearful of retaliation or losing their job perhaps someone would have stood up and stopped those prescriptions from being dispensed and administered. The culture of fear at the Tomah VA contributed to the preventable tragedy of Jason Simcakoski deaths as well as many others. The corruption at the Tomah VA runs very deep. Those who were willing to compromise patient safety and their ethics will continue to do so. I fear true reform is impossible as so many unethical practices have occurred and Veterans will continue to suffer the ultimate price.

Post-Hearing Questions for the Record
Submitted to Mr. Ryan Honl
From Sen. Tammy Baldwin

“Tomah VAMC: Examining Quality, Access, and a Culture of Overreliance on High-Risk Medications”

March 30, 2015

1. Lin Ellinghuysen, the Acting President of the local AFGE union that represents Tomah VA employees, states in her testimony, which will be entered into the record, that, “The most vulnerable employees in this type of destructive workplace culture are those with temporary appointments and recent hires still on probationary status because they have very limited protections against retaliatory terminations, suspensions and other unwarranted personnel actions. Management has targeted these employees with the fewest rights to set an example for other employees with permanent status and send a strong signal as to what will happen to them should they decide to speak up or disagree with care given to veterans.” Ryan and Noelle – both of you were employed at the Tomah VA for under a year. You both experienced retaliation for your whistleblowing. Would you say that your experience is the norm at the Tomah VA? When someone rocked the boat or questioned Dr. Houlihan’s authority at the VA, what usually happened?

Answer:

I think a good solution for increased protections for whistleblowers is to reduce the probationary period which is currently 1 year for most employees (I believe 2 years for some clinicians although I may be incorrect with that) to a 90 days probationary period. There has to be some sort of period to judge the competence of new employees that allows for their removal if they prove deficient. It could coincide with the training period which is essentially 90 days since a new employee gets a 30 day and a 90 day formal review from management. Longer probationary periods only allow for a potentially corrupt management to abuse the system and terminate an employee who comes in new and reports wrongdoing. In my case, if it had been a 90 day probationary period, I most likely would have stayed knowing that I would have had protections through any OIG investigation since they all go longer than 90 days. In the case of Dr. Kirkpatrick who committed suicide after being terminated within his probationary period months after he reported wrongdoing about narcotics over prescribing, it would have saved a life as proven by his final plea to the union of making sure it never happens to anyone again. Right now the system gives full protection to wrongdoers while those who simply raise concerns about patient harm and safety are left to the wolves.



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

MAY 15 2015

The Honorable Ron Johnson
Chairman
Committee on Homeland Security
and Governmental Affairs
U.S. Senate
Washington, DC 20510

Dear Mr. Chairman:

Enclosed are the Office of Inspector General responses to the post-hearing questions from the March 30, 2015, hearing "Tomah VAMC: Examining Quality, Access, and a Culture of Overreliance on High-Risk Medications." Thank you for the opportunity to testify and provide the requested additional information.

Sincerely,

A handwritten signature in black ink, appearing to read "Richard J. Griffin".
RICHARD J. GRIFFIN
Deputy Inspector General

Enclosure

Post-Hearing Questions for the Record
Submitted to Dr. John D. Daigh, Jr.
From Senator Tammy Baldwin

"Tomah VAMC: Examining Quality, Access, and a Culture of Overreliance on High-Risk Medications"

March 30, 2015

1. Heather Simcakoski testified to two important points that I would ask you to directly answer:
 - a. Jason Simcakoski did inform Tomah VA Police about sales of prescribed drugs at the Tomah VAMC. The OIG also interviewed the Tomah VA Police Chief in the course of the investigation. Did any allegations of drug sales ever arise from the Chief in your interviews?

VA OIG Response: The interview between OIG staff and the Tomah VA Police Chief did not specifically address allegations of drug sales at the Tomah facility. Following this interview, we requested all police reports for the past 3 years of drug sales or related events on the Tomah campus. The Tomah VA Police Chief's staff told us that there were no Uniform Offense Reports of anyone selling prescribed or illegal drugs on the Tomah VA Medical Center campus.

- b. Jason Simcakoski had service connected PTSD and was prescribed opioids by the Tomah VA. His family reported no serious physical conditions requiring pain medication. The OIG report states that you did not find documentation that opioids were being used to treat PTSD. Can you tell me if Jason Simcakoski was one of the patients reviewed by the OIG?

VA OIG Response: Mr. Simcakoski was not one of the cases reviewed for the administrative closure, *Healthcare Inspection – Alleged Inappropriate Prescribing of Controlled Substances and Alleged Abuse of Authority, Tomah VA Medical Center, Tomah, Wisconsin*.

Post-Hearing Questions for the Record
Submitted to Dr. Carolyn Clancy, Ms. Renee Oshinski, and Mr. Mario DeSanctis
From Sen. Tammy Baldwin

"Tomah VAMC: Examining Quality, Access, and a Culture of Overreliance on High-Risk Medications"

March 30, 2015

TO DR. CLANCY:

Question 1: Reports of unexplained deaths of patients at the Tomah VAMC have been shared with my office and with the committee at today's hearing. I am requesting that your team investigate the following individuals and the circumstances surrounding their deaths:

Jason Simcakoski
Angela Colby
Michael Bobak
Derik McGovern
Kraig Ferrington
Myron Feltz
Brittany Yarley-Bock
Jordan Savor
Chris Vinson Nieves
Dustin Lenzo
Robert Marsh

Three unexplained deaths in the Tomah VA parking lot.

24 death notice or medical exam calls reported by the Monroe County 911 Communications Center between January 1, 2010 and February 15, 2015 from the Tomah VAMC. Some of these the individuals listed above may be part of this count.

Will you ensure that your investigators look into all of these deaths and the circumstances surrounding them?

VA Response: VA takes very seriously the death of any patient and is committed to ensuring that each and every veteran receives the quality care that they have earned and deserve. Veterans Integrated Service Network (VISN) 12 conducted a local preliminary review of the records for individuals named above, as well as for the events reported through Monroe County 911 Communications Center. Tomah VAMC called the Monroe County 911 Communications Center to request the names of the 24 death notice or medical exam calls reported by the Monroe County 911 Communications

Center between January 1, 2010 and February 15, 2015 from the Tomah VAMC and were referred to the Monroe County Medical Examiner's office that was unable to provide those names. In an attempt to find these veterans, Tomah ran a list of all autopsies from 2007 - 2014. An external review by clinicians outside of the VA is in the process and is expected to be completed by mid to late July.

In addition, VISN 12 has launched an unprotected, external clinical review of random cases for the two providers in question. This is being completed by a team of expert clinicians outside of VISN 12. This review is in process and expected to be completed this summer.

The Office of the Inspector General is conducting multiple reviews of patients at Tomah; however, we do not have a comprehensive list of the patients included in their investigation. However, we are aware that Mr. Simcacoski's case is included in their review.

Question 2: In Mr. Simcacoski's testimony, he states that Jason, who had service-connected PTSD, was given a 90-day supply of Lorazepam, a benzodiazepine. VA's "Clinician's Guide to Medications for PTSD" notes that these addictive drugs have potentially negative consequences and should be used in the short term, for example for 5 days. Frequent reevaluation for side effects is also recommended.

Dr. Clancy, Marv Simcacoski testified that his son, who suffered from PTSD, was given a 90-day supply of lorazepam, which is a benzodiazepine. The VA guidelines state that, "because of these potentially negative effects, it is recommended that benzodiazepines must be used with great caution in PTSD. When they are used, short term use [for example, no more than five days] with frequent re-evaluation for side effects is recommended." According to Mr. Simcacoski, Jason's doctor never reassessed his condition or monitored for side effects. Why weren't the guidelines followed in that regard?

VA Response: VA takes very seriously any allegation regarding substandard care. One of our most important priorities is to keep our patients free from harm while receiving care at our facilities. The Office of the Inspector General is conducting multiple reviews of patients at Tomah and VA cannot comment on matters under investigation because to do so would be premature.

Question 3: Your clinical review findings for Phase 1 of your investigation into the Tomah medical facility found that Tomah patients were 2.5 times more likely than the national average to be prescribed opioids greater than 400 morphine equivalents per day and were more likely than the national average to be prescribed opioid doses between 200-300 morphine equivalents per day. With respect to the use of benzodiazepines and opioids concurrently, which is discouraged due to risks of complications, your team found that Tomah was

almost double the national average. In your opinion, are these prescribing practices at Tomah appropriate?

VA Response: Since the prescribing practices at Tomah are at the core of VA's ongoing investigation, we are unable to offer a formal opinion on the matter at this time. However, the clinical review findings for Phase 1 of the VA investigation found mixed results in the use of opioids at the Tomah VAMC. From the fiscal quarter beginning in July 2012 to the fiscal quarter ending in December 2014 the percent of pharmacy users receiving an opioid decreased 6% (2,124 to 1,994 Veterans), while the national percentage decreased 13% (679,376 to 587,762 Veterans). The percent change for this metric must be considered within the context that Tomah has a lower percentage of Veterans receiving an opioid compared to the rest of the VA. The percent of pharmacy users receiving an opioid or tramadol who are also receiving a benzodiazepine decreased 9% (611 to 554 Veterans), while the national percentage decreased 24% (122,633 to 93,352 Veterans). The percent of pharmacy users receiving opioids for longer than 90 days who also received a urine drug screen to monitor treatment increased 36% (453 to 712 Veterans, while the national percentage increased 31% (160,601 to 231,856 Veterans). The percent of pharmacy users who are receiving doses of opioids greater than or equal to 100 MEDD has not changed (274 Veterans), while the national percentage decreased 17% (59,499 to 49,356 Veterans)..

Question 3(a): Are these prescribing practices at Tomah consistent with VHA's clinical practice guidelines for prescribing opioids; for prescribing benzodiazepines; and for prescribing both drugs concurrently?

VA Response: VA is deeply concerned with and is actively addressing the overuse and dependence on opioid medications by Veterans. After many years of promoting the aggressive treatment of pain with powerful opioid analgesics, the United States is in the midst of an epidemic of misuse and abuse of opioid analgesics. The extent and complexity of our nation's Veterans multiple chronic pain conditions, including many severe battlefield injuries associated with blasts and co-morbid traumatic brain injury and/or psychological conditions such as depression and post-traumatic stress disorder, often make effective pain management clinically challenging and increase the risks for complications due to both over- and under-treatment with opioids and other therapies.

Per VHA clinical practice guidelines, the use of benzodiazepines and opioids concomitantly is discouraged due to risks of complications, including apnea and death. The clinical review findings for Phase 1 of our investigation suggest that Clinical Practice Guidelines (CPGs) for chronic opioid therapy may have not been correctly followed. However, as previously stated, our investigation is ongoing and we are unable to offer a formal opinion on the matter at this time. In the months following the clinical review findings for Phase 1 of the VA investigation at Tomah VAMC, the medical center has been vigorously pursuing implementation of the Opioid Safety Initiative (OSI) similar to other VA facilities to ensure optimal pain management and to safeguard Veterans from harm inherent

in high-risk medications such as opioids and benzodiazepines. The objective of OSI is to make the totality of opioid use visible at all levels in the organization with a particular emphasis on identifying and remediating prescribing practices that place Veterans at increased risk for adverse outcomes. To assist Veterans, providers and clinical teams in achieving OSI goals for safer opioid prescribing practices, an interdisciplinary VHA Task Force assembled a 15 module, peer-reviewed OSI Toolkit that is continually updated as new information becomes available, including new evidence-based practices. The OSI Toolkit is accessible to all VHA clinicians and disseminated widely and repeatedly through multiple communication channels and educational formats to facilitate safe opioid prescribing practices.

Question 3(a)(1): If yes, do you believe the relevant VHA clinical practice guidelines should be revised?

VA Response: We agree that it would be useful to update the guidelines with the latest evidence; a Chronic/Long Term Opioid Therapy Clinical Practice Guideline Panel is scheduled to begin work in September/October 2015. However, considerable work has already been completed in developing specific guidance for safe opioid prescribing in the Opioid Safety Initiative Toolkit which has been widely disseminated to VHA clinicians. These documents can be found on the VA Pain Management Intranet Site, <http://vaww.va.gov/PAINMANAGEMENT/index.asp>.

Question 3(a)(2): If no, what actions do you recommend to bring facilities like Tomah into compliance?

VA Response: Suggested actions would include a clinical consultation by an expert team followed by action plans to establish competent stepped clinical care for pain in primary care and in specialty care, as articulated in VHA Directive 2009-053.

The Tomah VAMC and VISN 12 leadership are committed to providing the best pain management to Veterans, who need such care. Specific steps taken at Tomah in past three months include:

- Implementation of pain resource folder in computerized medical record that is easily accessible to providers;
- Provider training on how to better leverage VHA's on-line opiate safety tools;
- Hiring a tracking nurse to help monitor and track Urine Drug Screen results and actions as part of a continuous monitoring/monitoring maintenance plan; and
- Provider education: in addition to academic detailing, VISN 12 has sponsored a pain management workshop on June 3, 2015.

Question 4: The interim clinical findings of your investigation found that Tomah was almost double the national average when it comes to rates of prescribing benzodiazepines and opioids concurrently, an unsafe practice that is discouraged due to risks of complications. As Mr. Simcakoski noted in his testimony, his son Jason was on so many medications, including a benzodiazepine and painkillers, the two of them couldn't keep track. Ultimately, at the time of his death, Jason was on 15 different prescription drugs, including anti-psychotics, tranquilizers, muscle relaxants, and opioid painkillers.

Please explain how this practice is allowed to happen if it's discouraged because it's so dangerous?

VA Response: VA takes very seriously any allegation regarding substandard care. One of our most important priorities is to keep our patients free from harm while receiving care at our facilities. VA cannot comment on matters under investigation because to do so would be premature. The majority of the medications prescribed to Mr. Simcakoski were classified as pain, anti-psychotic, tranquilizers or muscle relaxant and this combination was the primary focus point of the clinical review team assessment. It is not unusual to have a combination of medications in the mental health setting. However, to mitigate any risks related to a multi-medication regimen, tools are now in place to alert providers about periodic reassessment for continuation of therapy. The clinical review has also resulted in re-education on the use of panel management tools aimed to help providers when further patient review is needed.

Question 5: What is VA's protocol for monitoring opioid prescription and benzodiazepine prescription management for veterans being treated by non-VA providers – either through the CHOICE Act, or through non-VA provider payment (fee-basis) arrangements approved by VHA?

VA Response: There is no separate protocol for monitoring opioids and benzodiazepines prescribed by non-VA providers. Urgent opioid and benzodiazepine prescriptions are filled in non-VA pharmacies by Veterans who can then submit claims to VA's Chief Business Office for reimbursement. Non urgent opioid and benzodiazepine prescriptions written by non-VA providers are filled by VA and are therefore monitored as part of the ongoing Opioid Safety Initiative. For Choice patients who return to VA for care, the clinical record provided to VA by the Choice Third Party Administrators is available to the VA provider of record who can monitor opioids and benzodiazepines prescribed by the non-VA provider and if necessary, make adjustments. Twenty nine VAMCs transmit data to state Prescription Drug Monitoring programs, which allows queries to the State database to monitor care for all Veterans, including Veterans who receive non-VA care.

Question 6: I requested that your investigation team interview every person who wanted to speak up during the course of your review. In addition, my staff passed along a list of people who wanted to speak with investigators directly to your team on the ground in Tomah.

Has your investigation team interviewed everyone who wants to participate in the investigation, including the list of people who my office passed along?

VA Response: VA takes very seriously any allegation regarding substandard care and is cooperating with investigators in regards to the investigation. As there are multiple investigations with a variety of focuses, the Office of Accountability Review and the Veterans Health Administration are working to ensure a "warm handoff" between the teams and that those that wish to speak directly to the investigators.

TO MS. OSHINSKI:

Question 1: It is apparent to me that VHA lacks clear and appropriate system-wide policies and protocols as well as suffers from inadequate oversight of individual facilities. The dangerous prescribing practices and the widespread retaliation against employees at Tomah have proven that.

What's the proper role of the VISN and the VHA to ensure that facilities under their management aren't employing unsafe medical practices? Why didn't VISN 12 execute their oversight responsibility in the case of Tomah?

VA Response: VHA has identified and responded to challenges in pain management through policies supporting clinical monitoring, education and training of health professionals and teams, and expansion of clinical resources and programs. VHA's Pain Management Directive defines and describes policy expectations and responsibilities for the National Pain Management Strategy and stepped care pain model, which is evidence-based and has been adopted by the Department of Defense (DoD) as well. The VHA approach to managing opioid over-use addresses the problem of clinically inappropriate high-dose prescribing of opioids with OSI. In addition, VHA is working to develop interdisciplinary, patient-aligned pain management with the associated competency to provide safe and effective pain control and quality of life for Veterans.

Initiatives like OSI allow VISNs and VHA to identify variances in prescribing patterns as well as opportunities for system changes to ensure safe medical practices. In July 2013, VISN 12 established an Opioid Safety Initiative Steering Committee. Each facility, including Tomah, appointed a physician to serve as the facility Opioid Safety Initiative point of contact. VISN 12 has been involved in the VHA's development of a national Opioid Surveillance Dashboard in support of the safety initiative, and expanded reporting to include the development of customized reports on opioid management at

the facility and provider level. Medical record informatics solutions were also developed for provider education and to ensure providers addressed opioid pain care agreements and urine drug screens monitoring.

Facility-level data is discussed at monthly VISN Pain Committee meetings where sites share best practices/action plans. VISN 12 further developed supplemental VISN OSI-based reports to assist local teams in patient-level reviews.

In May 2014, VISN 12 conducted a network-wide survey of pain management resources and services to help facilitate communication between sites on the development of alternative treatment options. Provider education occurred concurrently, with sessions on prescribing and process changes. For example, one session was led by a psychologist on "How to Set Boundaries with Chronic Pain Patients." VISN oversight of the OSI focused on providing the facilities with the tools and training for the development of local action plans. Trending data on overall opioid usage, urine drug screens and high dose therapy management serve as a guide for the effectiveness of local actions.

The facility's expert on pain management for OSI at the Tomah VA Medical Center was actively participating with the VISN Pain Committee and OSI focus teams. The review and action plans for addressing OSI measures were implemented locally and under the direction of the facility Chief of Staff. Although local reviews were conducted on high dose patient management, the Chief of Staff was responsible for oversight. In retrospect, the issues identified have raised concerns about how we approach clinical oversight when a Chief of Staff also serves as a significant provider within a medical center. As a result of this experience, we are instituting a new process for peer review at Tomah. Clinicians from other sites will routinely be involved in these reviews and meetings to ensure outside viewpoints which would not be influenced by the reporting relationship at the facility.

TO MR. DESANCTIS:

Question 1: I wrote to you on April 7, 2014, requesting that you launch a full review and investigation into a number of matters under discussion today, including the concurrent use of benzodiazepines and opioids. Your reply more or less stated that everything was under control, essentially refuting every concern I raised with you on behalf of a constituent. In addition, you neglected to inform my office that the OIG had just finished a 3 year investigation of the facility and—you told me to contact the Tomah VAMC Associate Chief of Staff, who worked under Dr. Houlihan, if I had additional questions.

In sum, your letter to me said: nothing to see here and then it referred further questions about inappropriate prescribing practices to the leadership at the center of this controversy.

Mr. DeSanctis, in light of the evidence of inappropriate opioid and benzodiazepine prescribing and the tragic death of Jason Simcakoski, do you stand by your response to me? In retrospect, was everything really under control?

VA Response: The response provided to your letter of April 7, 2014, was based on the best information and data available at that time. We will have a better understanding of what changes may be necessary the OIG review of Jason Simcakoski's case is completed. Mr. DeSanctis worked with the Associate Chief of Staff for Mental Health, who with other staff, performed in-depth chart reviews of every patient enrolled in Tomah VAMC's residential treatment program for substance abuse in calendar year 2014 (Jan 1- Apr 8, 2014). Tomah VAMC recognized that there continues to be some professional debate and controversy relating to prescribing benzodiazepines in the treatment of PTSD, both in terms of general guidelines and in how those guidelines are applied in individual cases. The facility also noted the responsibility for individual treatment decisions ultimately lies with the attending physician or other provider responsible for a Veteran's care. Their decisions should be informed by the circumstances, needs, and preferences of that individual patient, and all the information available at the time. We did highlight in our response the importance of the issues you raised as it related to our facility, and where we were focusing our improvement efforts to address those issues. These improvement efforts included:

- Tomah VA participation in the VHA Psychopharmacology initiative to provide tools to review and drill-down data related to prescribing patterns. This initiative was established to also analyze cases with Veterans receiving various treatments, including benzodiazepines, correlated with certain diagnoses.
- The institution of the facility's Opioid Safety Initiative (OSI) which began in January 2014 and the multi-disciplinary Pain Management Committee that was charged with implementing the OSI.

Additionally, at Tomah VAMC, every Veteran's life is valued and respected. The staff and physicians involved and myself wish we could have prevented Jason Simcakoski's death. As of March 20, 2015, Mr. DeSanctis has been detailed to VISN 12, serving as the project lead for the implementation of the Veteran's Choice Program across the VISN. The results of the OIG review of Jason Simcakoski's case are still pending, and it would be premature to state what could have been done differently until it is completed. Once we receive this final report, the findings will be reviewed by our team and we will work to resolve the areas requiring improvement.

